Organisational Climate and Standards of Nursing Care: The Administration of Depot Neuroleptic Drugs to Psychiatric Out-Patients.

Gordon Neil Turner R.M.N.

Ph.D.

The University of Edinburgh

1994

Declaration

This thesis is my own work and no part of it has been submitted for a degree at this or any other university.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

This study was funded by the award of a Nursing Research Training Fellowship by the Scottish Office Home and Health Department and their support is gratefully acknowledged.

Particular thanks are due to Dr F.I. Atkinson who has patiently supervised this study since its beginning. His encouragement and interest in the work, and his preparedness to continue supervision after changing posts, is greatly appreciated. Thanks are also due to Professor P Prophit, who supervised the early work, and to Dr K M Melia for her supervision and support latterly.

I would also like thank all those who participated in the study, and in particular the nurses and patients involved. Finally, I would like to thank my wife, Ann, for her forbearance during my preoccupation with this study. This thesis is dedicated to the memory of my late younger brother, Neil, who died during its writing.

ABSTRACT

This study was designed to explore the quality of nursing care received by schizophrenic patients living in the community, and the relationships between the standards of care and features of the organisational environments experienced by nurses. Clinical settings involved with the administration of depot drugs to psychiatric out-patients were identified in four Managerial Sectors of a single Scottish Health Board. The administration of these drugs by nursing staff was observed for 202 out-patient attendances over a period of nine months. The standard of nursing care delivered during each depot drug administration was evaluated using a criterion referenced assessment instrument constructed for the study. Systematic field notes were recorded at the end of each observation to describe other aspects of care provided, including the topics addressed during contacts between nurses and patients.

The construct of Organisational Climate was used to explore the nurses' perceptions of their organisational environment. For purposes of the study Climate was defined as comprising of five organisational characteristics. The nurses' perceptions of Climate were assessed using a questionnaire in which asked nurses to indicate which of two alternative scenarios, reflecting a range of organisational characteristics, best described their working environment. They were also given the opportunity to express their personal opinions regarding these characteristics.

The findings showed that nurses placed the greatest emphasis on issues related to drug injection techniques while the wider concerns of long term depot medication therapy, including monitoring drug side-effects and assessing general health and social well-being, were generally given a lower priority. Significant differences existed between the four Managerial Sectors of the main study area in terms of both the standards of nursing care observed and the Organisational Climates reported by nurses. The highest standards of care were found to exist in a Managerial Sector where nurses dealt with significantly smaller numbers of patients and where they had access to more comprehensive information. The relationship between Climate and standards of care was also found to be significant. Where there was a greater emphasis on innovation, standards of nursing care, and aspects of organisational structure, higher standards of nursing care were observed.

The findings reveal important practical and theoretical concerns pertinent to the different standards of nursing care observed. The findings suggest that certain organisational characteristics were associated with the delivery of a higher standard of nursing care. The utlity of adopting an organisational approach in exploring nursing care issues is discussed. Recommendations for changes to the existing arrangements for depot drug administration within the study area are suggested.

CHAPTER ONE

Introduction to the Study

An essential feature of modern mental health care is the comparatively recent expansion in Community Psychiatric Nursing(CPN) services. Although the first CPN services were established in the 1950's it was not until the early 1970's that nurses could obtain formal post-registration qualification as community psychiatric nurses.

During recent years there has been a marked increase in the numbers of CPNs employed in the United Kingdom. White(1993) estimates that there are currently just under 5000 CPNs currently in the United Kingdom and that between 1985 and 1990 the number of CPNs increased by approximately 54 percent. This is reflected in the changing CPN/population ratios. White(1993) further reports that the CPN/population ratio in England increased from 1:23,800 in 1985 to 1:12,700 in 1990 and that the 1990 CPN/population ratio in Scotland was 1:16,100. This survey, conducted during 1990, also revealed that 62 percent of CPNs in Scotland had obtained a recognised post-registration qualification compared with 79 percent in Northern Ireland, 35 percent in England and just 16 percent in Wales.

White(1993) also found that over 70 percent of the CPN services who responded to the survey did not involve consumers in the planning of their services, and cited the findings of Munton(1990) in suggesting that a greater involvement of service users in the planning process ultimately reduces the influence of health care professionals, so that they may prefer not to actively seek the participation of users. Furthermore, as Ferguson (1993) points out, when dealing with psychiatric patients health care professionals may tend to assume

that the effects of illness may negate the judgements and opinions of patients. Consequently there exists a twofold reason for nurses to be disinclined to seek the views of patients regarding the service they provide.

In this survey over half the CPN services responding did not employ a recognised method of evaluating the services they provided. Since service evaluation is now becoming common, often to conform with arrangements for health care funding, this may result in a greater focus on the standard of nursing care that CPNs contribute towards the care and welfare of patients in the community. The development of performance criteria for nursing practice will therefore become essential and, as White(1993) suggests, the determination of such criteria is a relevant topic for research.

However, as Harrigan et al (1993) note, the tendency during evaluations of CPN services has been to focus more on structural issues such as the numbers of CPNs, caseload sizes, and the frequency of contacts with patients. This may largely be due to the ease with which such measures may be obtained compared with the collection of data regarding the standard of care provided to individual patients, along with any outcomes of this care. While accepting that standards of nursing care may be more difficult to measure it is imperative that the care actually provided to patients is addressed during any evaluation of CPN services. If not, then the contribution of CPNs towards the care of mentally ill patients in the community will have been inadequately assessed.

The needs of patients diagnosed as having schizophrenia are manifold. The illness presents as a complex network of needs which involve the patient, his family, and his interactions with the wider social world. Where patients are maintained outwith the hospital environment their need for support is most acute. The availability of adequate support services is an essential element in the policy of reducing the role of institutional care by maintaining mentally ill patients in the community, an integral component of which will be the contribution of CPNs.

Development of the present study began as a result of the researcher's experiences of managing an acute psychiatric admission ward. This ward had an additional function involving out-patients attending on a regular but informal basis for depot drug injections. An initial investigation by the researcher showed that the numbers of these patients imposed a considerable workload for the nursing staff (Turner 1984). Given that the ward's main priority was to care for psychiatric emergencies, the needs of those patients attending for depot drug injections was a lesser priority. Concerns about the adequacy of arrangements were further aroused because of the brevity of nursing contacts with these patients. Only when a patient's condition caused immediate concern was a nursing assessment carried out in any detail. The emphasis of care was invariably focused on the administration of the injection and ensuring that any patients who failed to attend were contacted.

As a consequence of these preliminary enquiries the task of depot drug administration to the patients concerned largely became the

responsibility of the local CPN service. This change raised wider questions concerning arrangements for depot drug administration. It was apparent that the majority of depot drug contacts between CPNs and out-patients would take place in community settings and therefore might not be immediately visible to service managers and other carers so that, much as before, these patient contacts remained somewhat hidden.

Although the number of injections given by CPNs could be easily established there was no information regarding either the situations they encountered or the range of nursing interventions they carried out during depot drug administration contacts. As such the standard of nursing care provided and the level of demand for depot drug injection could easily be overlooked during any evaluation of the service. A further concern was that the depot injection contact might be viewed a being a task-orientated event with the main objective being that of administering injections rather than providing a more comprehensive package of nursing care.

For many patients their most frequent contacts with mental health services are the regular appointments with nurses to receive depot drug injections. This is particularly the case when patients are in remission and have fewer acute mental health care problems. However, such patients are always at risk of relapse and nurses involved with depot drug administration are particularly well placed to monitor progress and identify any issues of concern regarding the continued health and welfare of these vulnerable patients. Given the aim of maintaining patients in the community for as long as possible the

extent to which nurses constructively utilise these regularly occurring depot drug contacts to both assess patients and contribute to their care is of paramount concern.

Depot drug administration has been noted as being a key activity of CPNs and continues to account for a high proportion of their contacts with patients. However, these important contacts have not been the subject of specific study. Therefore, and in order to explore the extent to which nurses used the opportunity afforded by depot drug administration, a study of the nursing aspects of depot drug administration arrangements is proposed.

Nursing services form part of the larger organisation of the National Health Service(NHS), and are further devolved to Health Boards and, subsequently, to clinical settings. Therefore, concepts drawn from studies of organisations were adopted in order to explore important issues impacting upon the CPN services dealing with depot drug administration. This involves obtaining data on the practical issues surrounding depot drug administration arrangements, such as the number and type of settings used. However, since CPN services are a component of this larger organisation, it is also relevant to consider what other organisational characteristics might influence the standards of nursing care provided for patients.

Of the range of concepts pertinent to the study of organisations, Organisational Climate was selected as providing a useful basis to explore these. Climate has the advantage of permitting a range of pertinent organisational characteristics to be investigated, rather

than focusing exclusively on a single issue. Consequently, the nature of the organisational environments experienced by nurses can be described in terms of a range of characteristics, and the relationship of each of these to the standards of nursing care observed can be explored.

The following four research questions are proposed;

1) What is the standard of nursing care occurring during contacts between schizophrenic out-patients and nursing staff when depot drug injections are administered in community based settings?

2) Within the study area what are the arrangements for depot drug administration, and what are the workload demands on the nurses and settings involved?

3) What are the organisational characteristics experienced by participating nurses, as revealed by the measurement of Climate?

4) What is the relationship between these organisational characteristics and the standard of nursing care observed during depot drug administration contacts?

CHAPTER TWO

Schizophrenia, Chemotherapy and Nursing Care

Much of the current understanding of mental illness and the development of modern mental health care services originated in the period from the late 19th century to the early years of the present century. An important aspect of the development of these early services was the recognition that mentally ill people required care and support.

There were then no effective treatments for mental illness comparable with modern chemotherapy and early mental health care services are characterised by the construction of large mental illness hospitals, or asylums as they were then commonly known. These asylums; a term which implies sanctuary, represented the emerging caring philosophy of those times. The role of these large institutions has since reduced and in more recent years many have closed. The availability more effective drug treatments for certain forms of mental illness has reduced the need for hospitalisation resulting in a move towards more community orientated services for the mentally ill.

It should be recognised that developments in the nursing care of psychiatric patients cannot be seen in isolation from medical practices. Medical treatment has many nursing implications, one of which is the important role nurses play in administering medically prescribed drugs. These drugs are now often administered outwith the traditional hospital setting and this is particularly the case with the depot drug preparations, where a regular injection is involved. It has been noted that the development of effective chemotherapy has been an important factor in the emergence of CPN services since the

1950's, when anti-psychotic drugs first became widely available (Brooker et al 1993). Patients receiving depot drugs are likely to have been diagnosed as having a major mental health disorder of the type encompassed by the term schizophrenia.

Achieving the policy imperatives of maintaining schizophrenic patients in their communities involves a number of issues. They will require treatment for their mental illness and close monitoring of their progress so that the likelihood of relapse and readmission to hospital is minimised. This monitoring will also involve their compliance with drug treatment and the extent to which they may experience any of the side-effects associated with chemotherapy. Such patients, and their families, will also require more general care and support if they are to remain in their communities for as long as is possible. Issues such as social skills and behaviour, family relationships, financial and employment arrangements, and the general well-being and welfare of patients become increasingly pertinent outwith the hospital environment.

Those patients receiving depot drugs will have a regular contacts with nursing staff in order that they can receive their injections. The extent to which nurses are able to utilise this contact to assess needs and provide nursing care is therefore a vital component of the support provided to maintain schizophrenic patients in their communities.

Schizophrenia

The term schizophrenia was first used by Bleuler(1911). Subsequently the nature and causation of the forms of mental illness implied by this term became the focus of much debate and research within the medical profession. In more recent years attempts have been made to establish a more commonly accepted definition of schizophrenia, and to describe and classify the major features which differentiate this illness from other forms of mental illness. The main features of schizophrenia are summarised in the Diagnostic and Statistical Manual of Mental Disorders(American Psychiatric Association 1980);

> **"The essential feature of this group of disorders are; the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months. The disturbance is not due to an Affective Disorder or Organic Mental Disorder. At some phase of the illness Schizophrenia always involves delusions, hallucinations, or certain disturbances in the form of thought."**
> (American Psychiatric Association 1980 pp181)

The care of the schizophrenic patient has been described as **"the heartland of psychiatry and the core of its clinical practice"** (Kendell 1983). The nature of symptoms such as hallucinations and delusions can result in behavioural problems, difficulties in personal relationships, and may also affect the patients well-being in areas such as diet and hygiene. The assessment of active symptoms is important, particularly in younger patients who are acutely unwell. Some patients will eventually present with a more chronic condition in which the acute symptoms are minimal but where social functioning is grossly impaired.

This 'defect state' is described by Kendell(1983);

> **"He becomes apathetic, no longer strives, no longer cares. At the same time, and perhaps fundamentally for the same reason, he loses interest in other people and his capacity to form enduring emotional relationships is reduced...It is this apathy and emotional blunting which make schizophrenia the terrible illness it is, because they are permanent changes in the personality which handicap the subject in every sphere."**
> (in Kendell and Zealley(1983) pp281)

Of those with this condition some will have been ill for many years and will have accrued considerable personal and social handicaps. The insightless and avolitional schizophrenic patient may often be unable to function adequately in social terms and may also be subject to fluctuations in his mental state. Such an individual living in the community will require a considerable range of supports.

Chemotherapy in Schizophrenia

The introduction of anti-psychotic drugs is closely associated with dramatic changes in the management of schizophrenic patients. Before the advent of these drugs the care of schizophrenic patients was largely custodial in nature. This involved the removal of patients from their communities and an additional consequence was that many subsequently became institutionalised. As a result, and in addition to the effects of their illness, some patients lost the social and personal skills required for them to successfully return to life in their communities.

Early drug therapy was primarily used to sedate patients who became distressed or disturbed. The new anti-psychotic drugs also had a tranquillising action but were additionally able to modify some of the symptoms of schizophrenia. As a result the mental state of patients could be dramatically improved and the effects of their illness sufficiently controlled so that they no longer required the same degree of custodial supervision.

When first introduced, in the 1950's, anti-psychotic drugs were only available in short-acting oral formats. The compliance of patients with prescribed drug regimes proved to be a major obstacle to effective treatment and this was especially the case for oral preparations. In the care of schizophrenic patients, where impaired insight and a lack of volition are common symptoms, evidence exists to show compliance was a problem. Renton et al(1963) found that 46 percent of a sample of schizophrenic patients living in the community were not compliant with oral drugs.

Given the known efficacy of anti-psychotic drugs in reducing relapse rates (Pasamanick et al 1969, Leff and Wing 1971), compliance was obviously a key factor in effective clinical management. Compliance can be viewed as the being the extent to which a person will modify their behaviour in response to advice (Haynes 1979), which for these patients means taking the drug treatments as prescribed. In terms of health care this is related to the awareness of an individual regarding the nature of their illness, and their desire to prevent or reduce their susceptibility to illness or to modify the effects of their existing illness. In view of the symptoms of schizophrenia

the monitoring of compliance continues to be a particularly important aspect in meeting the needs of these patients.

By the mid 1960's anti-psychotic drugs became available in depot format which allowed administration by deep intra-muscular injection at regular intervals, which for most patients were between one and four weeks. This change in the mode of drug administration improved treatment by reducing the risk of non-compliance (Eberhard and Hellbom 1986), as patients had to be seen regularly by a health care professional in order to receive their injections. Depot drugs proved to hold so many advantages that by the 1980's Eberhard and Hellbom(1986) claimed that neuroleptic drugs, particularly in the depot form, had become **"...the mainstay in the treatment of chronic schizophrenia."** However, since many patients receiving depot drugs may also be prescribed concurrent oral drugs (often to control the side-effects of the depot drugs) then compliance with these remains an important concern.

Drug Side-Effects

Although anti-psychotic drugs have many benefits there are also associated side-effects. The most important of these are the three types of movement disorder. Dystonia produces involuntary muscle contractions. Akathisia commonly presents as a discomfort in the arms and legs and can result in marked restlessness. Tardive dyskinesia is characterised by movements of the mouth and tongue which may be both irreversible and resistant to treatment. The incidence of tardive dyskinesia is common and has been found to

affect between 27% and 31% of schizophrenic patients (Robinson and McCreadie 1986). The problem of side-effects is of obvious importance in terms of both the patients general health and also in the continued compliance with treatment. Davidhizar et al(1986) reported that of the negative beliefs held by patients about their drugs, 30% were specific to physiological effects. As such the presence or poor control of drug side-effects may have implications for the willingness of patients to continue to accept treatment and comply with their prescribed drug regime.

In view of these risks the monitoring of drug side-effects of clearly an important issue. This is particularly so for patients living in the community where contacts with mental health services may be fewer than when in hospital, so that when contacts do occur drug side-effects should be routinely monitored. For these patients the regular contact with nurses prompted by depot drug injections presents an obvious opportunity for the monitoring of drug side-effects to occur.

Depot Drug Usage

A number of studies have indicated that the administration of depot drugs to schizophrenic patients living in the community is extensive (Cheadle et al 1978, McCreadie et al 1984, Freeman and Alpert 1986). More recently Bamrah et al(1991) found that 62% of a sample of 269 schizophrenic out-patients in an urban community were receiving depot drugs from CPNs and that depot-receiving schizophrenic patients in this area, including those in hospital, received an

average of 21.6 depot drug injections annually. Johnstone et al(1991) reported that depot drugs were a component of treatment in 78% of a sample of over 500 schizophrenic patients followed-up after discharge from hospital.

Studies confirm that the administration of the depot drugs tends to be almost exclusively undertaken by nurses. In addition to giving injections, these contacts also permit nurses to make a more comprehensive contribution to the care of these patients. Nurses dealing with depot drug administration are also ideally placed to act as information gatherers and to communicate progress, or any matters of concern, to significant others such as medical or social services staff.

Johnson and Wright(1990), although writing mainly about drug prescribing, proposed that the contact afforded by depot drug administration was the ideal opportunity to regularly monitor patients living in the community. Any failure of nurses to do so would not only represent an unacceptable standard of nursing care, but may also prejudice the ability of some patients to remain in the community. This would be compromised if important issues such as a deterioration in the patients mental state or an acute domestic or personal problems were overlooked, or were not dealt with promptly, due to an inadequate nursing review during depot drug contacts.

Social and Personal Needs of Patients

The advent of effective chemotherapy, and in particular the depot drugs, has resulted in more effective treatment of the symptoms of mental illness. Although the need for close monitoring of patients remains, in terms of both their mental state and the risks of treatment, this has resulted in a greater potential for such patients to live outwith the hospital environment. However, effective chemotherapy represents only a partial solution to the problems of maintaining schizophrenic patients in the community. Chemotherpy, in schizophrenia, does not represent a cure. Although lengthy remission may occur in some patients there remains the possibility that many will relapse.

In addition the modification of symptoms does not imply that these should no longer be of concern to nurses and that they do not continue to influence the quality of life of patients. Patients will also have needs related to finance, housing, and employment. They may be dependent on the benefits system and be involved with other agencies, such as Social Work. Patients will also require basic living skills, such as budgeting, shopping and cooking, if they are to attain a socially acceptable quality of life whilst in the community.

Effective community supports will be essential and in many cases may extend to the involvement of families and friends in addition to that provided by health care staff and other agencies. An awareness in those providing support of the nature of schizophrenia, along

with an ability to cope with any social and behavioural effects of the illness, are critical issues if patients are to remain in the community. It has long been recognised that the inability of relatives to cope with schizophrenic patients may be related to higher re-admission rates (Brown et al 1962, Leff et al 1982). The relationships between schizophrenic patients and their significant others in the community, and their families in particular, is clearly an important issue for professionals providing mental health care support.

However, chemotherapy cannot be viewed as an absolute solution to the management of schizophrenic patients. Drug treatment may be instrumental in enhancing the potential for many schizophrenic patients to live in the community but for patients to thrive their wider range of needs must be met by the caring services. The regular nursing contact afforded by depot drugs administration represents an important opportunity for many of these needs to be monitored and, where appropriate, for nurses to take a positive role by initiating nursing interventions.

Nursing Role in the Community

The first Community Psychiatric Nursing service was established in 1954 at Warlingham Park Hospital. Greene(1968), describing another early service, summarised the nursing activity required using five categories. To provide physical and psychological nursing care; to be part of a multi-disciplinary team; to provide support to the patient and his family; to undertake a preventive role in health

issues, and to act as a consultant to non-psychiatric nurses on matters of mental health care. As Brooker et al(1993) point out an important aspect of the inception of CPN services was the availability of better drug treatment;

> **"...the impetus for the establishment of CPN services in the mid-1950's was the introduction of the phenothiazine drugs, which established a new demand for the follow-up and aftercare of such patients."**
> (in Brooker and White(1993) pp46)

Pollock(1989) gave twelve rationales to account for the development of CPN services. Amongst these she cites issues such as government policies and the reduced role of institutional care for the mentally ill. She also specifically notes the role of more effective drug treatment and, in particular, the availability of long-acting depot preparations.

Carr et al(1980), with reference to Barker(1977), proposed that the role of the CPN had six components; 1) the CPN as a consultant to other professionals; 2) the CPN as a clinician with specific nursing skills and interventions; 3) the CPN as a therapist, in the psychotherapeutic sense; 4) the CPN as an assessor of clinical needs and the care given; 5) the CPN as an educator of patients, their families and also other staff; and 6) the CPN as a manager. Carr et al(1980) go on to state that;

> **"These six areas encompass most of the component parts of the role of the community psychiatric nurse and most present day community psychiatric nurses are involved in all the mentioned areas."**
> (Carr et al(1980) pp25)

Griffith and Mangen(1980), in a review of studies of the CPN, also identify a range of activities appropriate to the CPN role. These include; giving drugs and monitoring drug side-effects; providing support and advice to patients and their families; dealing with the physical needs of patients; helping with employment and accommodation; providing a link between the community and the hospital; promoting appropriate social behaviour; being involved with socially active groups, and locating out-patients and defaulters. Barker(1981) suggested that the main components of the CPN role are: assessor and therapist; nursing consultant to other professionals, and monitoring the effects of drugs.

In these various prescriptions of the CPN role the issue of drug administration is often cited, as are various others which together suggest that CPNs should expect to deal with a comprehensive range of patient needs in addition to the demands of drug administration. As White(1993) points out, the administration of depot drugs is an integral component of the role of the CPN but little is yet known about what other therapeutic effects these regular contacts with nurses have beyond the injection of drugs.

Nursing Involvement in Depot Drug Administration

For many patients their contacts with nurses for depot drug injection will represent their most frequent contact with health services. There is however evidence to suggest that the opportunities afforded by the depot drug injection contact are not being fully utilised by nurses.

The nursing role in relation to this type of drug administration has not been specifically investigated but researchers who have studied community mental health services have often commented on depot drug activity. Thomson(1982) found that nurses tended to give depot drug administration a low priority and Turner(1984) found that depot drug administration to out-patients often occurred informally and was not deemed to require any particular facilities or a specifically designated nursing input.

In one study of CPNs it was found that 41% of all nursing contacts with schizophrenic patients occurred at depot drug clinics but that these contacts accounted for only 4% of the nurses working time, where the average contact duration in these clinics lasting for only three minutes (Sladden 1979). Thomson(1982), also raised the topic of the brevity of contacts. He describes a situation where injections were given to eight different patients in separate locations, within a period of 75 minutes. Hunter(1978), in a study of the provision of care to schizophrenic patients, commented that;

> **"Disappointment was expressed by some of the patients and caregivers about changes they had experienced starting with the patient being given Moditen** [a depot drug] **injections. A number said this was associated with the stopping of conversation with the nurse, and they missed this."**
> (Thomson(1982) pp90)

Wooff et al (1988) contrasted the activities of CPNs and social workers and found that the mean duration of contacts with schizophrenic patients was substantially shorter for the CPN group. In 80% of CPN contacts drugs were administered and these contacts

were characterised by **"...very short contact times, the administration of medication and referral for consultant opinion if symptoms worsened."**. The main thrust of CPN involvement was the administration of drugs and nurses did not often exhibit evidence of either initiating other forms of nursing intervention or conducting a more comprehensive assessment of patient needs.

There is also concern that the changing demands made on CPNs may reduce their availability to schizophrenic patients. Bamrah et al(1991) reported that CPNs were becoming more involved with patients suffering from neurotic illnesses and personality disorders and that, consequently, they spent less time with schizophrenic patients. Wooff and Goldberg(1988) also noted that non-psychotic patients were occupying a greater proportion of CPN workload and that this may partly account for the short duration and emphasis on drug administration medication observed during contacts.

Wooff and Goldberg(1988) further suggested that a lack of managerial involvement in CPN caseload arrangements may be of concern where General Practitioners(GPs) make direct referrals, so that the composition of caseloads may have consequences for CPN activity. They suggest that the traditional style of nurse management might result in a situation where the managers of CPN service do not themselves possess the clinical skills and experience required to fully support CPNs in their dealings with patients.

More recently Bowers(1993) commented on both the positive and negative aspects of depot injection clinics. He notes that depot

clinics do provide a frequent contact which allows for regular regular monitoring and that there is the opportunity for social interaction, especially since many of the patients and nurses involved may have known each other for some time. In addition the requirement of patients to attend a clinic involves them in taking a degree of responsibility and participation in their own treatment programme. For nurses the depot injection clinic may also be cost-effective in that unnecessary and time consuming home visits are avoided. However, there are also negative aspects in that depot clinics may be perceived as a low status task and a result there may be a focus on the giving of injections to the detriment of wider issues involving the patients mental state and personal or social circumstances.

Bowers(1993) goes on to make a series of recommendations designed to encourage good practice in depot injection clinics. Every patient should have a responsible key worker and, whenever possible, depot injections should be given by their 'own' CPN. Adequate time should be allowed for contacts at depot clinics and there should be a systematic monitoring of both drug side-effects and each patients personal needs whilst living in the community. Attendance at a depot clinic should be supplemented by regular assessments involving home visits and each patient should have their drug regime regularly reviewed by a qualified psychiatrist. Effective procedures should be developed to ensure that patients who fail to attend are promptly contacted. Access to depot clinics should be sufficiently flexible so as to encourage attendance, such as by arranging evening sessions for patients in employment. Finally, patients should be consulted

and their views regarding the service they receive taken into account by service providers.

Implications for Research

This evidence raises important questions regarding the activities of nurses and the ways in which they exploit the contacts required by depot drug prescribing. Some nurses may see their role mainly as that of an injection giver, since the duration of some contacts suggests that it is unlikely that any other nursing interventions could have occurred with any regularity. As such only the most basic objective of giving an injection may have been attained during some contacts. There may also be an assumption that because patients are being regularly seen by CPNs for depot drug injection that their other needs are also being monitored. As Wooff and Goldberg(1988) point out, such an assumption may not be justified;

> **"...the evidence suggested that the ways in which CPNs are trained, and the ways in which services based upon 'injection clinics' operate, are unlikely on their own to provide either adequate frameworks for systematic and regular review of symptoms experienced by long-term patients, or for the review of psychosocial problems."**
> (in British Journal of Psychiatry(1988) pp34)

Therefore, it may be speculative to assume that during depot drug contacts that either the desired components of the CPN role suggested by Carr et al(1980) and Griffith and Mangen(1980), or the recommendations of Bowers(1993) regarding good practice in depot injection clinics, would be in evidence. Not only may standards of nursing care be inadequate, but the potential of the depot drug

contact as an opportunity to effectively monitor and care for patients may not be fully recognised or exploited. These concerns are pertinent for both nurses who conduct depot drug contacts and those responsible for the planning and organisation of mental health care services.

In recent times the the issue of caring for the mentally ill in the community has become particularly topical. The closure of many large mental hospitals has resulted in an increased focus on caring for patients in the community, and has emphasised the need to ensure that patients are properly supported when they leave hospital. Official statistics(Scottish Health Statistics 1991) reveal that the numbers of schizophrenic in-patients in Scotland has reduced from 3400 in 1985 to 2742 in 1991.

These statistics also show that since 1985 approximately 3000 annual admissions to in-patient care in Scotland are due to relapsing schizophrenic patients. The costs of re-admission to hospital are considerable in terms of both health care resources and the personal consequences for patients and their families. In view of the findings in previously published surveys(Bamrah et al 1991, Johnstone et al 1991) it is likely that the many of these relapsing patients will have been regularly attending nurses for depot drug administration.

It is not suggested that more thorough nursing assessments during depot drug contacts would necessarily reduce re-admissions to hospital. However, it is reasonable to suppose that the

circumstances leading to re-admission might be more effectively managed, and time spent in hospital possibly reduced, if contacts associated with depot drug administration were being fully exploited by nurses.

Therefore, a study to describe and explore the extent to which nurses constructively use depot drug contacts is indicated. Since the standard of nursing care given to patients represents an important concern then the practical arrangements of care delivery, and the constraints and opportunities which influence the clinical activities of nurses, are relevant issues. Where different standards of nursing care are encountered, whether inadequate, acceptable or excellent, the keystone to understanding these may be found in the nature and effects of the organisational characteristics experienced by the nurses concerned.

CHAPTER THREE

An Organisational Approach to Nursing Care

In the previous chapter the needs of schizophrenic patients in the community were discussed. It was concluded that a study was required to explore and evaluate the standards of nursing care during contacts between nursing staff and schizophrenic patients arising from the need to administer depot drugs.

A frequently used approach to the evaluation of health care services was proposed by Donabedian(1966). This permits care to be viewed in terms of Structure, Process and Outcome. The structural dimension consists of aspects of the care providing agency such as equipment, resources, and management style. The process element describes the actual giving of care to patients, including the clinical decision making involved. Outcomes refer to the results of care for patients in terms of any change to their health care needs.

Bloch(1975) suggests that studies which relate primarily to either processes or outcomes might not fully address the complex issues of nursing care. She advises that it is more useful to consider both aspects simultaneously when evaluating care. Studying the processes of care without pursuing any outcomes does not permit the care given to be evaluated in terms of the intended consequences. Similarly, a focus on outcomes without an awareness of the preceding care processes would not reveal why particular outcome criteria were, or were not, attained.

Studies of community psychiatric nursing include those which are primarily process based, where the range and type of nursing interventions employed are the main focus. These processes are

sometimes expressed in the form of treatment goals although, as Pollock(1989) points out, they may be couched in imprecise terms or task-centred definitions. Additionally, some studies of psychiatric nurses reveal that they may define their treatment goals to accord with the views of medical staff(Towell 1975) or display no obvious conceptual basis at all for the care they provide(Altschul 1972).

Outcomes of care have less often been the focus of study, presumably because these are more difficult to quantify and measure. Studying outcomes in terms of benefits to patients from CPN involvement may require extended periods of time. For mentally ill patients any changes may occur slowly and might be minimal, or imperceptible, over short time periods. Studies that include a patient satisfaction instrument often use data from this as a form of outcome measure. While this is undoubtedly of value in view of the current consumer emphasis in health care provision the extent to which patients are satisfied does not necessarily imply that the care they received was either appropriate to their needs or accorded with any defined standard.

Furthermore, the care of schizophrenic patients will often involve drug treatment and contributions from a number of professional groups or agencies in addition to that made by nurses. As such it may be difficult to define and monitor outcomes which can be specifically attributed to nursing processes. In any event, and except perhaps for specific issues such as the monitoring of drug side-effects, outcomes from the comprehensive package of care required by schizophrenic patients are perhaps best evaluated

against the overall benefit to the patient. However, it is essential that any nursing contribution to the care of these patients can at least be described and evaluated in terms of the standard of nursing care provided, even if this does not extend to specified nursing outcome measures.

Structural issues are not usually investigated to the same extent. This may be because, as Harrigan et al(1993) point out, that in CPN research structural factors are often viewed simply in terms of numbers of CPNs and caseload sizes. These are often reflected in the findings of surveys, such as White(1993), in which the changing numbers of CPNs and patients are documented. Structural issues are less often investigated from the perspective of their impact on the clinical activities of individual nurses.

However, as Bloch(1975) notes, the structural framework of evaluation also applies to the 'system' which provides the care. Therefore, structural factors can extend beyond the numbers of staff and patients to include the characteristics of the organisation that provides and supports the processes and outcomes of nursing care. Just as an emphasis on either processes or outcomes in isolation results in an incomplete evaluation of nursing care(Bloch 1975) a failure to consider in sufficient detail the relationship between structural components and care processes or outcomes results in a similarly incomplete evaluation of nursing practice.

There are important structural factors which will directly influence nurses and, therefore, the standard of care they provide. In this

study the relationship between these, which will include the various characteristics of the organisation providing nursing care, and processes of the nursing care provided by CPNs during depot drug contacts will be explored from the perspective of concepts found in the organisation theory literature.

Organisational Concepts

The clinical activities of the individual nurses who will participate in this study occur within the organisational environment of the NHS. It is therefore pertinent to consider what effects the characteristics of this organisation have on the standard of nursing care it provides for patients. An organisation has been defined as **".... a social system that has an unequivocal collective identity, and exact roster of members, a programme of activity and procedures."**(Caplow 1964 pp1). On the basis of this definition the term organisation can be widely applied and will encompass organisations of varying size, composition, and purpose.

Within the many different forms of organisation a range of characteristics may be found. The presence of specific organisational characteristics, and the ways in which these are manifested, will vary dependent on the nature of the organisation concerned. A number of different organisational characteristics are known to exist simultaneously in organisations and it may be necessary to consider a range of these if an organisation is to be comprehensively described in terms of organisational theory. This is of particular concern when studying a large organisation with many

sections, functions and staff groups. Furthermore, in such an organisation a wide range of practices and procedures may be encountered so that it is essential to consider which particular characteristics are likely to be encountered in the area to be studied.

The focus of this study is the activities and experiences of nurses working within a single organisation. Although the organisation concerned is large it is the arrangements for the delivery of mental health nursing care by CPNs which is the focus of interest. As such the relevant organisational concepts are those which are most likely to influence the nurses whose care is to be observed. It is these which will most directly influence their activities and, therefore, the standard of nursing care they provide for patients. In this chapter key concepts in the organisational literature pertinent to a nursing study will be discussed. Concepts which can be utilised to illuminate observed standards of nursing care observed during depot drug contacts will be selected and their usage in this study described.

Organisational Goals

An organisational goal has been defined as **"...a desired state of affairs which the organisation seeks to realise."**(Etzioni 1964). The issue of goals is relevant to the study of nursing care in that any required nursing activities formally defined by the organisation can be considered to represent, in part, its goals for nursing. As such the extent to which a health care organisation defines expected or

desired standards of nursing care is of relevance when evaluating the nursing care provided for patients.

Etzioni(1964) considered that goals can serve three functions. They can provide an orientation by depicting a future set of affairs which the organisation strives to realise. They may also provide a source of legitimacy which justifies the activities and existence of the organisation. Goals can also form a standard against which the success of the organisation can be evaluated.

Mullins(1985) suggested that there were four types of organisational goal. Consumer goals are those relating to supplying particular goods or services to meet the requirements of the consumer. Product goals relate more to the nature of the specific product or service being supplied. Operating goals are those which specify the activities required to maintain the internal functioning of the organisation and the product it generates. Secondary goals are related to these other goals but are less visible, such as the training needs of staff.

In a large organisation each of these types of goal can be found. While such goals can be useful for describing activities or plans there is the potential for some may conflict or be dependent on the success of other goals. There are limitations if an organisation is studied only from the perspective of attaining specific goals, which can be illustrated using a hypothetical example.

An organisation with the goal of supplying customers with an improved product may be dependent on several related goals involving the technical expertise required of staff and access to specialised equipment in order to manufacture the product. The corollary here is that any investment in skills or equipment would be wasteful unless the goal of making an improved product was later justified by consumer demand and sales. Therefore, if such an organisation were evaluated solely in terms of successfully achieving the technical and manufacturing goals there would result a false assumption about the health of the organisation if, subsequently, there proved to be no demand for the improved product.

Etzioni(1964) noted that goals are often expressed to reflect ideal states or unrealistic expectations. In comparison with these many organisations would appear to fail if goal attainment alone were the sole criteria of success. Conversely, if goals are set too conservatively then success may be judged only in relation to easily achieved goals. In this scenario the organisation can initially appear successful but might ultimately suffer from a lack of progress and innovation, particularly where competitors have more adventurous goals.

Etzioni(1964) also noted the importance of differentiating between formal and real goals. The formal goal, which states 'what is to be achieved' may differ from the real goal which reflects 'what is actually being done'. An individual may not perform in the manner required by the formal goal for a variety of reasons. He may be unaware of the precise nature of the goal or may not have the

resources or skills required. He may disagree with the goal and elect upon an alternative course of action. There may also be a tendency for some individuals to revise their own goals to be compatible with those against which they know their performance is to be evaluated and concentrate their efforts accordingly(Zola and McKinlay 1974).

Pollock(1989) proposed that CPNs formulated three types of goal. Immediate goals were patient focused while Intermediate and Ultimate goals related to more general objectives, such as the Ultimate goals of **"helping the patient to cope"** or **"promoting independence".** Sladden(1979) found that goals expressed by CPNs could be so vague that **"....objectives of care lacked specific purpose and direction, with the result that it would often have been impossible to say whether or not they had been met."** Cormack(1983), in a study of psychiatric nurses, found three types of goal. Direct goals-formal were those that were stated with a degree of precision and were known to both nurses and patients. Direct goals-informal were more vague and were not necessarily appreciated by nurse or patients. Indirect goals arose from the consequences of nurses acting as facilitators for others.

However, in nursing studies, goals tend to be mainly process based and primarily address how nurses themselves determine what care is required by individual patients. While these treatment goals are an essential element of nursing practice the extent to which these accord with, and are supported by, more formal organisational goals is worthy of investigation. Where organisational goals do encompass

nursing standards then the extent to which these are compatible with nursing practice is of obvious interest. There is clearly a potential for differences between the formal nursing goals of the organisation and the treatment goals of individual nurses. There is also the possibility that formal organisational goals may fail to address standards of nursing care at all, so that any defined care objectives are determined by nurses themselves. Additionally, nurses may also be expected to comply with formal organisational goals that do not directly related to standards of nursing care. The extent to which compliance with these other goals is conducive to, or conflicts with, nursing practice is also a pertinent issue.

In this study it is intended to address the issue of goals by exploring the extent to which standards of nursing care are formally defined and monitored by the organisation. Related issues such as available resources and the degree to which the organisation supports nurses in updating their skills and knowledge in line with clinical developments will also be addressed.

Social Roles

In order for an organisation to function effectively it is necessary that individual members are able to identify and enact their own specific contribution to the activities of the organisation. A prescription for the activities of an individual within an organisation is their social role.

Katz and Kahn(1978) proposed the framework of the role episode. A role is defined by one or more role senders and is based on their expectations and requirements for a particular focal person; the individual whose role is being defined. This role episode has four distinct stages. Role Expectations are defined by role senders in terms of their requirements for the focal person. These expectations can also form criteria against which the performance of the focal person can be evaluated. There then occurs the Sent Role stage, when the role expectations are communicated to the focal person. This is followed by the Received Role, when the focal person perceives the role being sent to them. This perception may also be influenced by their own personal role expectations; their 'self-sent' role. Finally there occurs Role Behaviour when the focal person enacts their role. Role senders are then able to consider the appropriateness of the role behaviour in terms of their role expectations.

In view of the complex multi-disciplinary nature of most health care organisations in which nurses work an individual nurse may occupy more than one role and may relate to a number of role senders. Merton(1957) proposed the concept of the 'role set' to describe the situation of a focal person interacting with a number of role senders, all of whom hold some role expectations for that focal person. As Gross et al(1958) point out the extent to which a focal person can determine the consensus view of his role set will be an important determinant in his actual behaviour.

Since a focal person may receive a variety of sent roles there is the potential for some of these to be incompatible with others. The term role conflict proposed by Katz and Kahn (1978) describes this phenomenon. Four types of role conflict were proposed. Intra-sender conflict describes the situation of a single role sender holding conflicting expectations for a focal person. Inter-sender conflict occurs where members of the role set each hold conflicting expectations for a focal person. Inter-role conflict arises from the focal person having roles in different organisations, or different parts of an organisation. Person-role conflict occurs where the focal person's personal perceptions of their role conflicts with those of their role set.

Merton(1957) identified strategies which individuals might employ to minimise role conflict. Differences in the relative importance of demands will require a focal person to determine priorities from the range of sent roles. Because an individual might not interact with all the members of his role set simultaneously he may be able to fulfil potentially conflicting role expectations at different times. In addition members of the role set may themselves recognise the existence of conflicting demands and attempt to resolve the conflict by modifying their demands. Finally, mutual support may be obtained from others occupying similar roles where advice can help in resolving or coping with conflicting demands. An individual may also experience role strain when unsuccessfully attempting to fulfil conflicting roles, or role ambiguity where a lack of precision in the sent role makes it difficult to determine what is required of them.

The extent to which CPNs feel that their role has been defined, is understood by others, and is congruent with their clinical activities are important issues in this study. Also of interest is the role played by the nurse managers to whom CPNs are responsible, since these managers are presumably important members of the role set of CPNs. Whether CPNs are able to respond to the demands of their defined role or whether they experience any difficulties in doing so, such as role conflict or strain, will also be explored. The earlier discussion revealed that a number of roles have been defined as being components of the activities of CPNs (Carr et al 1980, Barker 1977). How, or whether, activities compatible with these roles are reflected in the observed nursing care of CPNs is also of relevance.

Organisational Structure

In order to carry out functions and achieve their purpose, organisations require some form of organisational structure. As Pugh and Hickson(1976) point out:

> **"...all organisations have to make provision for continuing activities toward the achievement of its given aims. Regularities in activities such as task allocation, supervision and coordination are developed. Such regularities constitute the organisations structure and the fact that these activities can be arranged in various ways means that organisations can have different structures."**
> (in Pugh and Hickson (1976) pp51)

This statement clearly implies that organisational structures are not uniform and that differences are likely to be observed between

organisations. Pugh and Hickson(1976), following a review of the literature, proposed that structure comprised of six components.

Specialisation refers to the division of labour within the organisation according with its different functions. Standardisation involves the development of procedures and rules to meet particular situations, while Formalisation reflects the extent to which standardised procedures and rules are converted into written policies. Centralisation describes the location of authority within the organisation, and relates to Formalisation where roles and responsibilities are defined. Configuration refers to the relationships between position in the organisation, and is often reflected by organisational charts showing lateral and vertical spans of control. Flexibility reflects the potential of the organisation to respond to change.

In subsequent work by the same authors the first five of the components were explored by the administration of a questionnaire to 52 organisations. From the results three key dimensions of structure were revealed. Structuring of Activities results from a combination of Specialisation, Standardisation and Formalisation and reflects how the activities and processes of the organisation are expressed as procedures and policies. Concentration of Authority is essentially the original Centralisation component and indicates the levels of responsibility and decision making. Line Control of Workflow encompasses the control mechanisms exercised by line managers through formal procedures.

Child(1972) considered that the potential consequences of a deficient structure would be undesirable for any organisation. Poor morale and a lack of motivation would occur in the absence of appropriate standardised rules, or where the number of rules was excessive or were considered to be irrelevant. Individuals may also feel they had little responsibility or authority and that their achievements were not being recognised. Competing demands and an absence of priorities may result in poor coordination and supervision. Decision making may occur slowly and previous decisions might subsequently be seen to have been poorly evaluated at the time. Conflict may arise where decisions taken may not have involved those actually doing the work, so that managers and staff may have separate agendas.

Structural dimensions address a wide range of issues, such as management style, communication and decision making and standards of performance. For nursing, the nature of the organisation structure may pose a dilemma. As Georgopoulos(1972) suggests, exploring the formal structure of a hospital organisation may have limited value since the variety of activity inherent in a health care setting may not be fully documented or prescribed in the formal structure. As such the structure may not represent a comprehensive definition of all the activities that occur within the organisation.

While the structural characteristics of a health care organisation are undoubtedly relevant to a study of nursing practice an assumption that the formal structure will comprehensively reflect nursing activity cannot be made, so that adopting the formal

structure as the sole basis of an organisational approach to nursing practice is inadequate. Only those activities contained in the structure would be studied with the result that other important aspects of nursing activity might be ignored.

However, since some form of a structure will exist it is essential to consider whether or not the components of this are effective in terms of facilitating and supporting nursing care. It would therefore be of value in this study to address certain structural issues. The most important of these, from the perspective of nursing practice, is the extent to which any formal policies and procedures that nurses are expected to comply with deal with standards of nursing care. Also of relevance are factors such as whether nurses have sufficient information, the effectiveness of communication arrangements, and to what extent nurses were involved in decision making.

Organisational Climate

It has been suggested that a range of organisational characteristics are likely to influence nursing staff. The characteristics of particular interest those which most directly impact upon practising nurses. In this study the nurses concerned are CPNs caring for schizophrenic patients and who have regular contacts with patients during which depot drugs are administered. The specific issues of organisational goals, structure and roles have all been discussed and it is proposed that these are all pertinent in a study to evaluate standards of nursing care. It is also suggested that each

of these, although relevant to nursing practice, has limitations if used in isolation.

Exploring nursing organisation from the perspective of a range of organisational characteristics, including goals, structure and roles, would result in a more comprehensive description of the organisational characteristics experienced by nurses. This also permits the relationship between several of these characteristics and standards of nursing care to be explored. The concept of organisational climate meets this requirement.

An essential feature of climate is that a range of organisational characteristics can be explored simultaneously. The definition given by Pritchard and Karasick(1973), which they describe as a synthesis of earlier definitions, usefully summarises the components of climate:

> **"...one might define organisational climate as a relatively enduring quality of an organisations internal environment distinguishing it from other organisations; (a) which results from the behaviour and policies of members of the organisation, especially top management; (b) which is perceived by members of the organisation; (c) serves as a basis for interpreting the situation; and (d) acts as a source of pressure for directing activity."**
> (in Organizational Behaviour and Human Performance(1973) pp126)

The consensus in the literature is that the key feature of the climate is its usefulness in describing the characteristics of an organisation from the perspective of its individual members. As Schneider(1975) points out, climate will exist in every organisational setting since all individuals will require to comprehend the various issues influencing their activity at work.

They will do so in order to adapt their behaviour to accord with their experience of the organisation. It follows then that the work performance of an individual in a particular organisational setting might be better understood if the prevailing organisational characteristics influencing them are also known.

A similarity between the concepts of climate and job satisfaction was suggested by Johannesson(1973) and has been the subject of some debate in the literature. Johannesson(1973) viewed that climate and job satisfaction were essentially one and the same, because the early climate measures had been largely abstracted from job satisfaction instruments. This view is refuted by both Payne et al(1976) and Schneider(1975), who propose that job satisfaction is concerned more with a persons subjective view of their particular job expressed in terms of their personal needs and values. Conversely, climate refers to their description of the organisational environment in which they work. Payne et al(1976) give a clear explanation of the difference between job satisfaction and climate:

> **"...the measures are conceptually different in two ways: firstly, job satisfaction is focused upon a particular job, while organisational climate refers to the organisation as a whole: secondly, job satisfaction concerns a persons affective response to his job, while organisational climate is derived from a persons description of what the organisation is like.** (in Organizational Behaviour and Human Performance(1976) pp46)

Dimensions of Organisational Climate

The various definitions proposed for climate accord with the view that organisations contain a range of characteristics. Commentators have suggested that some of these characteristics might be more

represented in climates than others. Lawler et al(1974) and James and Jones(1976) both suggested that issues related to activity processes would be most evident while Jessor and Jessor(1973) proposed that organisational characteristics which are most distant from the individual, such as the overall size of the organisation, would be less evident in their climates. As Jones and James(1979) suggest climate will relate more to the immediate issues of tasks, processes and roles which affect individuals rather than to the more global characteristics of the organisation.

In a review of the literature Campbell et al(1970) suggest that studies had revealed that climate consisted of four key dimensions. Individual Autonomy concerns the freedom of an individual to innovate and make decisions. Position Structure describes the degree to which the job content is defined and is communicated to the employee. Reward Orientation reflects the extent to which effort is rewarded while Consideration, Warmth and Support involves work relationships. These dimensions of climate can be seen to incorporate important organisational characteristics. For example, both the Individual Autonomy and Position Structure relate to aspects of social roles and organisational structure. James and Jones(1976) point out that the four climate dimensions proposed by Campbell et al(1970) might not be sufficient to fully describe all organisations and that additional or alternative dimensions might be appropriate in some situations.

Schneider(1975) also viewed that, in practice, the notion of a prescribed set of climate dimensions was not necessarily essential

for research, since different organisational situations are likely to involve different characteristics in any event. He suggests that researchers may also wish to explore climate in relation to a specific issue; for example, the climate for innovation. However, as James and Jones(1979) state, the views of Schneider(1975) do not exclude the likelihood that a defined set of dimensions would be sufficient to describe many organisational situations.

Measuring Organsiational Climate

Given the diversity of organisations, and consequently their climates, no single instrument has been constructed which has been shown to be reliable and valid for all types of organisation. This is in accordance with the views of Schneider(1975) that climate is intrinsic to the practices and procedures of the specific organisation. Since climate can comprise of a variable range of characteristics that are not necessarily identical in every organisational situation then a single climate instrument which is universally applicable is an unlikely development.

Of the climate instruments constructed the best known is that of Litwin and Singer(1968). Their instrument contained 50 items, using a four point Likert response, grouped into nine scales. After the application of the instrument to 500 respondents, in a variety of organisations, they concluded that three of these scales were addressing a single dimension and should be combined. There were, however, questions regarding the validity of some of the scales and this concern was acknowledged by the authors themselves. Such was

the importance of this instrument that other researchers (Sims and Lafollette 1975, Muchinsky 1976) applied it in order to explore the issue of validity and reveal dimensions of climate.

Sims and Lafollette(1975), after conducting factor analysis on responses to the Litwin and Singer(1968) instrument proposed that six dimensions of climate were revealed;

1) General Affect Tone Toward Other People - the way in which an individual perceives colleagues and other associates.

2) General Affect Tone Toward Management - perceptions about immediate management, which may also represent perceptions about the organisation in a more global sense.

3) Policy and Promotion Clarity - perceptions about promotion policies.

4) Job Pressure and Standards - expected performance standards.

5) Openness of Upward Communication - describing communication flow and the receptiveness of management to suggestions from employees.

6) Risk in Decision Making - the potential consequences of a specified course of action.

They concluded that their derived factors had higher overall reliability than those derived by Litwin and Singer(1968) and that some of the original scales had unacceptably low reliabilities. Further analysis showed that items from each of the nine original scales loaded into a range of factors, with majority loading into factors One and Two. As the labels imply, Sims and Lafollette(1975) suggested that these two factors contained primarily affective responses, and their results led them to conclude that there was some doubt regarding whether the original Litwin and Singer(1968) scales were indeed describing organisational characteristics or were, instead, measuring the attitudes of people.

Muchinsky(1976) extended the work of Sims and Lafollette(1975) by administering the same Litwin and Singer(1968) instrument. Using the same factor analysis technique he also derived six factors;

1) Interpersonal Mileau - describing the interpersonal environment; the 'atmosphere' of the organisation.

2) Standards - the perception that the organisation had established exact standards of performance

3) General Affective Tone Toward Management/Organisation - an identical definition to that of Sims and Lafollette(1975)

4) Organisation Structure and Procedure - perceptions of the way 'things get done'.

5) Responsibility - describing perceptions about the location of authority, individual autonomy, and decision making.

6) Organisational Identification - a feeling of being part of the organisation, and loyalty to the organisation.

Muchinsky(1976) also found, like Sims and Lafollette(1975), that the same original Litwin and Singer(1968) scales had low reliabilities. Although there were similarities, his results differed regarding the loading of items into derived factors. Muchinsky(1976) suggested that this may have been a consequence of his applying the instrument in a different type of organisation to that used by Sims and Lafollette(1975). This suggestion accords with the views of Schneider(1975) that climate perceptions are specific to the organisation concerned so that such differences can be accounted for by variations in the practices and procedures of the different organisations studied.

Although the extent to which the Litwin and Singer(1968) instrument is descriptive is debatable it is apparent that the items included were an attempt to address major organisational characteristics such as structure, social roles, organisational goals, performance standards and innovation, and working relationships. Jones and James(1979) suggest that the literature reveals four major domains which, if investigated, are **"...an important step in developing a measure of psychological climate."** These four domains are consistent with most definitions of climate dimensions found in the literature. Job or role characteristics may be encountered such as variety,

challenge, job pressures, and role ambiguity. Leadership behaviours such as support, goal emphasis, and initiation of structural features may also be evident. Workgroup and social environment characteristics such as friendliness and cooperation between colleagues are also important. Climate will also be influenced by any local issues which have relatively direct ties to individual experience.

In summary climate is a particularly useful organisational concept since all organisations, or even component parts of a large organisation, will have identifiable climates (Schneider 1975). The consensus in the literature is that climate is primarily a descriptive concept which can consist of a number of dimensions that will relate to important organisational characteristics such as structure and social roles.

Measuring Organisational Climate in Nursing

Climate has been infrequently studied in nursing so that climate dimensions specific to a nursing situation have not been previously determined. Claus and Bailey(1976) suggested a series of guidelines for the analysis of climate in a nursing setting. Although they cited relevant issues, and aspects of the climate dimensions proposed by Jones and James(1979) are clearly implied, their suggestions do not represent a series of measurable climate dimensions.

Cope(1981) attempted to explore the climate experienced by nurses in a study of changes in a psychiatric hospital made in response to critical findings. He developed a questionnaire to obtain staff views containing a section labelled 'organization climate'. The author himself conceded that items in some scales are addressing the same issues as items in other scales, so that the various scales might not be measuring mutually exclusive organisational issues. In addition the author also comments scores from the 11 sections were **"...grouped together as meaningfully as possible as general measures of how nursing staff feel about these issues."** to obtain results, but does not give the rationale for either formulating items or allocating items to scales.

The extent to which the construction of this instrument reflects identifiable dimensions of climate in terms of organisational concepts is debatable, given the lack of information on how items were formulated and were allocated to the various scales. There is also concern that some items clearly describe an attribute of the individual rather than of the organisation. For example; **"Quite often I feel like staying home from work instead of coming in.".**

The instrument developed by Cope(1981) to measure climate in a nursing situation therefore appears incompatible with the definition of climate given earlier. Although developed with the intention of measuring climate in a nursing situation this instrument cannot be viewed as being suitable. Therefore, a questionnaire to measure climate in nursing will be constructed specifically for use in this study.

Using Organsiational Climate in this Study

In order to measure climate in a nursing context the questionnaire will comprise of five sections. Each section will reflect organisational concepts appropriate to nurses since, as Muchinsky(1976) suggests, it is acceptable to define dimensions of climate in accordance with the nature of the organisation to be studied. The various items in each section will be formulated to address issues which are relevant to the major organisational concepts described earlier in this chapter. As such the extent to which the five individual section scores vary in their contribution to global climate scores will reveal any differences or similarities in the constituents of climates experienced by nurses.

While climate will be considered as being a descriptive concept the personal views of nurses cannot be easily ignored. It is therefore intended to give nurses the opportunity to indicate their personal views regarding each of the organisational characteristics they are asked to describe. By giving nurses the opportunity to both describe and give their opinion in response to each item it is hoped that this will reduce any tendency for them to emphasise their opinions rather than describe their situation, as might occur if only a single response to each item was sought. This takes into account the views of Johannesson(1973) regarding the potential similarity between climate and job satisfaction, and heeds the warning of Payne et al(1976) regarding the importance of separating descriptive and affective views of the organisation.

The five components of climate which will be addressed in this study are detailed below. Each of these addresses a range of issues compatible with important organisational characteristics, including structure, goals, and social roles.

Climate Section 1 - Introduction of New Ideas and Innovations

In the various prescriptions of the dimensions of climate(Campbell et al 1970, Jones and James 1979) the issue of innovation and the response of the organisation to new ideas is not specifically identified. However these issues are implied in the climate dimensions they propose. For example, the Risk scale in the Litwin and Singer(1968) climate instrument includes items directly relating to innovation. However, in a community nursing context, this is a particularly important organisational issue.

CPNs may tend to work in partial isolation and may often be required to respond to quickly to rapidly changing circumstances. As a consequence formulating nursing strategies to deal with specific clinical situations will be required of CPNs. The extent to which they are able to innovate in terms of their nursing practice, or implement changes to the organisation of their workload and related administrative procedures, are important concerns. Whether the organisation enables and encourages CPNs to propose innovations, and subsequently implement any changes, will also be addressed.

Climate Section 2 - Effective Organisation of Nursing Activity

This section essentially describes the organisation structure experienced by nurses. Issues relating to organisation structure are common to most definition of climate dimensions. The items will reflect components of structure which accord with those proposed by Pugh and Hickson(1976), such as rules, regulations, communication, information, and decision making. The extent to which these various structural components apply to nurses, or address nursing practice issues, will be described.

Climate Section 3 - Roles of Nursing Staff

The issue of role is also a commonly cited component of climate. The issues addressed in this section will include whether job descriptions accurately reflect the roles and responsibilities of these nurses. The extent to which nurses experience problems such as role conflict, and whether their nursing managers are prominent members of their role set, will be also explored. Further items will be included to reveal whether nurses had any delegated authority and whether or not they felt they had acquired the skills and knowledge relevant to the duties expected of them.

Climate Section 4 - Warmth and Support at Work

Inter-personal relationships feature in previously defined climate dimensions(Jones and James 1979). In this section nurses are asked to describe relationships with colleagues and managers in terms of

whether people are supportive when a problem occurs and have trust in one another. Nurses will also be asked to describe whether guidance and advice is freely available and if a sense of team spirit exists. Whether the organisation's response to dealing with mistakes is undertaken in a constructive or punitive manner will also be addressed.

Climate Section 5 - Standards of Nursing Care

Standards of nursing Care as a climate dimension is obviously unique to a nursing situation. However, issues related to performance standards have been defined as a dimension of climate(Litwin and Singer 1968). For nurses performance standards can be considered to include their clinical practices. Although data about the actual standard of care provided will also be collected it is important to note that this section of the climate instrument refers to the extent to which the organisation specifically and formally defines and monitors standards of nursing care.

Nurses will be asked to describe whether standards of nursing care are discussed, defined, and subsequently implemented. Whether there are formal monitoring procedures to ensure that defined standards are achieved will also be addressed. Nurses will also be asked to describe whether there are sufficient resources available so that they can attain an acceptable standard of nursing Care, and whether or not the organisation takes active steps to keep them up to date with developments in nursing practice.

Summary

It has been proposed that concepts found in the organisation theory literature are relevant to the study of nursing practice. Some of the problems associated with adopting a single organisational characteristic were discussed earlier. A major concern was that a number of organisational characteristics would be experienced by nurses so that concentrating only one of these would not fully reflect the range of organisational issues experienced by nursing staff.

The concept of organisational climate does, however, provide a more useful basis to explore these characteristics, since a more comprehensive description of the organisational environment experienced by nurses can be obtained. Moreover, since climate data are obtained directly from nurses themselves then the researcher need not assume that certain organisational conditions exist simply because they are formally defined elsewhere. Finally, there results a direct correspondence between climate findings and standards of nursing care, since the data regarding each are obtained from the same source.

Therefore, in this study, climate will be utilised as a construct within which a range of relevant organisational concepts may be explored. Various issues related to these concepts form the basis of the five sections of climate described earlier, and are reflected in the 30 items contained in the climate questionnaire. In previous research climate has been used as an intervening variable(Litwin

and Singer 1968, Dieterly and Schneider 1974). In this view the attributes of the organisation are perceived by members and, in turn, have consequences for outcomes such as work performance and job satisfaction.

In this study climate also will be viewed as an intervening variable acting between the attributes of the organisation, as these are experienced by CPNs, and the standard of nurse care observed during their contacts to administer depot drugs to schizophrenic out-patients. As such variations in the standards of nursing care observed will be explored in terms of differences in the prevailing climates influencing nurses and their working practices during depot drug administration contacts.

CHAPTER FOUR

Study Design and Methods

In the previous chapters important issues regarding the management of schizophrenic patients in the community were highlighted. In particular the potential value of the regular contact with nurses in order for patients to receive depot drug injections. Such patients will have considerable social and health care needs and for many the alternative to their being maintained successfully in the community might be re-admission to hospital.

For the monitoring of compliance and drug side-effects, the practicalities of drug administration, and the well-being of schizophrenic patients, the regular contact afforded by depot drug administration provides an ideal opportunity for nurses to contribute to their care. Indeed, for some patients, the regular contacts arising from the need to administer depot drug injections may represent the only occasions during which nurses can make their contribution. The extent to which nurses constructively use this opportunity is the major focus in this study.

The organisational characteristics experienced by nurses involve important factors which will influence their clinical activities and, therefore, the standard of nursing care they provide for patients. As such, establishing what these organisational characteristics are both illuminates findings regarding the standards of nursing care and permits the relationship between these and standards of nursing care to be investigated. Organisational Climate, in this study, will be used as a construct within which a range of organisational characteristics relevant to a nursing situation will be explored.

In order to answer the research questions the study design required is that of a survey combining both the observation of contacts between nurses and patients in a variety of settings, and measurement of the organisational climates experienced by participating nurses. Within the study area the arrangements for nurses to administer depot drugs to out-patients will be identified and a number these contacts will be observed.

Data on the observed standards of nursing care during depot drug administration contacts will be collected during non-participant observation using an instrument constructed by the researcher for this purpose. These contacts will be further described by categorisation based on the content of the field notes made by the researcher. Climate will be measured by the administration of an questionnaire developed by the researcher specifically for use in this study. Data will also be collected to describe the characteristics of the nurses, patients, and settings involved in depot drug administration in the main study area.

Main Study Area and Access Arrangements

The study took place within the mental illness services of a Scottish Health Board. These services were part of the single overall Mental Health management structure within this Health Board. This service was further devolved, on a geographical basis, into four Managerial Sectors, each of which had separate managerial arrangements reporting to a Unit General Manager.

Access was gained in accordance with local procedures. Since all of the depot drug settings were part of a single management structure the consent of both the Unit General Manager and Unit Nurse was required first. At the time there was no established ethical committee for nursing research within these mental illness services but a procedure had been established where researchers, once the consent of the Unit General Manager had been obtained, were required to seek the consent of local managers. The local managers in each of the four managerial sectors involved were contacted and access was approved.

From each of the four sectors the various settings involved in the administration of depot drugs to out-patients were identified. The researcher had defined a setting as being some form of clinic at a location in the community or within a hospital site where out-patients attended to receive depot drugs. A total of 18 such settings were identified, of which 16 were used to collect data during the main study. One of the two remaining settings was used to conduct the pilot study and in the other the nurse concerned declined to participate.

Selection of the Sample

Within each of the settings identified during access negotiations the nurses responsible for the administration of depot drugs were invited to participate in the study. It was explained that they were consenting to the presence of the researcher during contacts with patients, provided that the patient also consented, that they would

be asked a series of questions and would be asked to complete a questionnaire. Observations were made in each of the 16 settings where nurses agreed to participate in the study.

It had been revealed during access negotiations that the various settings operated on different days and at different times. As such the availability of the part-time researcher to conduct observations became an important practical consideration. It was anticipated, and later confirmed during the pilot study, that appointment systems might not be used or be rigidly adhered to, so that arranging to attend a contact involving a specified patient would prove both impractical and time consuming. Not only would contacts involving other patients attending be ignored, when they could easily have been observed, but if a specified patient failed to attend then valuable time would have been wasted.

Therefore, in view of these practical constraints, a random sampling method was considered inappropriate since contacts might be selected which the researcher was unable to observe or the patient might fail to attend. The sampling method chosen therefore precluded the selection of named patients and instead involved observing the complete sequence of patient contacts scheduled for each of the depot drug administration sessions that the researcher was able to attend.

As such the sampling method used was a form of convenience sampling, since this method proved to be most the effective in terms of both obtaining the required volume of contacts within the availability of the researcher and minimising disruption to the nurses and patients

involved. An important consequence of this sampling method was that the numbers of observations from each session could vary dependent on the number of injections scheduled during each session. This variation subsequently proved to be of interest in illustrating the different working practices between settings.

In order to provide some structure to the number of contacts observed within this sampling method the researcher attended a minimum of two sessions in each setting. Further sessions were only attended where the number of contacts observed from the initial two sessions was less than five for each nurse. The researcher had determined that a minimum of five contacts should be observed of each nurse so that they had sufficient opportunity to demonstrate a range of nursing interventions. The inclusion criteria, aside from consent, was that the patient would receive a depot drug injection during the observed contact.

Development and Construction of Research Instruments

All of the tools used in the study were developed by the researcher. A Criterion Referenced Index was constructed to record details of the nursing interventions observed. Field notes supplemented this in order to record other aspects of contacts, such as the content and pattern of conversations. These field notes also provided the means to subsequently classify contacts as described later in this chapter. Additional data collection sheets were used to record information describing characteristics of nurses, patients and settings. An Organisational Climate questionnaire was developed

in order to obtain the perceptions of nurses regarding the extent to which certain organisational characteristics were features of their immediate organisational environment.

Criterion Referenced Index

To answer the research questions it was necessary for the researcher to construct an instrument which, for the purposes of this study, would measure the standard of nursing care during each contact. Therefore any differences in these standards of nursing care between groups of contacts could be revealed.

Waltz, Strickland and Lenz(1986) identify two principal approaches to measuring standards of care: the 'norm referenced' and the 'criterion referenced' methods. Norm referenced measurement involves comparing the performance of a subject with the known performance of others. Criterion referenced measurement is used to determine whether or not a subject has exhibited a predetermined set of behaviours. Since the standard of nursing care practised within the study area regarding depot drug administration had not been documented, nor was there an existing defined standard of nursing for such contacts, a criterion referenced instrument (Waltz et al 1986) was developed by the researcher to measure standards of nursing care.

The selection of criteria for inclusion in the Index was undertaken by obtaining a consensus of expert nursing opinion. Seven individuals were identified, in consultation with a senior nurse

manager, each having relevant knowledge and experience of depot drug administration. These experts consisting of two CPNs, two ward charge nurses, two nurse managers and a nurse tutor. During the interview with each expert they were asked to identify the range of nursing interventions that they considered would be appropriate during contacts involving the administration of a depot drug in typical circumstances, along with any other issues that they felt should be addressed by nurses.

The interventions and issues identified by these experts, and subsequently included in the Index, are those which a nurse administering depot drugs might expect to be relevant in the care of patients during depot drug contacts. For the purposes of this study these interventions form a standard for nursing care against which actual nursing practice can be compared. Nurses should therefore be prepared to assess or intervene regarding any of the Index items. As one expert commented, these criteria should be in every nurses "armoury" of possible interventions when dealing with patients receiving depot drugs. It was anticipated that these interventions would include drug related issues, particularly the monitoring of drug side-effects and drug compliance, along with physical and mental health issues and the social and personal circumstances of patients.

From the consultation with experts, 22 appropriate nursing interventions were identified and included in the Index. The experts were also asked to consider, since non-participant observation was to be used, in what manner the nursing activity related to each of

the Index criteria might be enacted by nurses, thereby allowing the researcher to determine whether certain Index criteria had been observed. For 19 of the 22 criteria it was anticipated that a verbal enquiry, or some form of verbal exchange during which the nurse sought and obtained information, would be expected. For some Index criteria, such as those related to the monitoring of drug side-effects, there was also the likelihood that some non-verbal nursing activity might also be appropriate, probably in the form of a more physically orientated nursing examination.

For the three Index criteria involving specific measurement (Pulse, Blood Pressure and Temperature) a physical examination only was anticipated. The scoring system allowed a score of one for those criteria where only a single form of nursing activity, either by verbal enquiry of physical examination, was anticipated. For those criteria where both verbal enquiry or physical examination could occur the scoring system allowed a score of one for a verbal enquiry and two for a physical examination.

It was also anticipated that during observation the researcher might not, because of lack of familiarity with nurse and patient, correctly identify some nursing interventions indicating that an Index criterion had been addressed by the nurse. Therefore, after each contact and when the patient had departed, nurses were invited to summarise their concerns during the contact. Where a nurses comments indicated that an Index criterion had indeed been a factor in their actions but had not been identified by the researcher during observation a score was awarded. Where observation and

subsequent discussion with the nurse indicated that some interventions had not occurred a score of zero was recorded against the Index criteria concerned. The comments made by nurses during the post-contact discussion were documented in the field notes. The duration of the contact was recorded to the nearest minute after the departure of the patient.

Nurse, Patient and Setting Information Schedules

Attached to the Index were the data collection sheets used to record information regarding the characteristics of nurses, patients and settings. This was particularly useful in practical terms in ensuring that the nurse, patient and setting data were permanently retained with the record of the standard of nursing care observed during each contact. The field notes were also attached to the Index.

The nurse information collected allowed the researcher to establish the nurses qualification in terms of any post-basic qualification specific to community psychiatric nursing, and their length of service in mental health care. Also collected were the numbers of patients regularly seen and the proportion of these who received depot drugs. The setting information identified the setting as being one of three distinct types, along with the numbers of patients attending and the proportions receiving depot drugs. Additional information on the use of records and appointment arrangements was also obtained.

The patient information identified both personal characteristics and drug related information. These included the age and sex of patients, and whether they lived alone or with other people. Patients were also asked to identify their most important community support so that some impression of the relevance of the personal contact with nurses could be gained. The drug related information involved establishing the frequency of attendance for depot drug administration and concurrent prescription of a range of oral drugs. It was essential to confirm whether or not patients were currently taking oral drugs in order to determine whether it would be relevant for nurses to explore the issue of oral drug compliance. Information regarding specific oral drugs was not sought but was often volunteered by patients.

Organisational Climate Questionnaire

In the discussion of organisational concepts, climate was viewed as being of a descriptive rather than affective nature (Schneider 1975). However, as was also suggested earlier, it is essential to differentiate between descriptive and affective responses when measuring climate. The climate questionnaire developed allowed nurses to both describe and give their personal opinions regarding each characteristic. As such any tendency for nurses to emphasise their personal opinions, rather than describe their organisational environment, was minimised in that they were given the opportunity to do both.

It was proposed that, for this study, climate would comprise five sections with each representing major organisational characteristics. Within each of these sections six component issues were identified. It was not assumed that each of the component issues in each section would be of equal relevance in all organisational situations. As such the allocation of an identical score to each component issue would be inappropriate. In order to determine a more appropriate score for the component items in each section of the instrument a group of 60 nurses from within the study area were was asked to determine the rank order of the six components of each section.

Each component issue was expressed as a statement and the 60 nurses were asked to rank the six statements in each section by assigning values to each. Allocating a value of one identified the issue that in their view the most important characteristic in the section, with the allocation of a value of six identifying the least important. During analysis these values were reversed so that the most important was allocated a score of six and the least important a score of one. The mean rank value of each statement within each section was then used as the weighted score for each of the 30 descriptive items in the climate instrument.

In order for nurses to describe the extent to which the various organisational attributes addressed in the instrument were a feature of their organisational environment each statement was then amended to a format of a pair of statements representing opposite scenarios. Respondents were then asked to indicate which of the pair of

statements best described their immediate organisational environment, with space being provided for any additional comments. Where a nurse indicated that a particular organisational characteristic was a feature of their organisational environment then the previously calculated score for that item was allocated. The affective response of nurses regarding each of the components was obtained by using a 7 point self-rating visual analogue scale; where 1 represented 'unimportant' and 7 'essential'. Each analogue scale item was specific to each of the 30 pairs of statements. The Organisational Climate instrument is contained in Appendix B.

The sixty nurses who ranked the organisational statements for the descriptive part of the climate instrument were also asked to complete a questionnaire containing items expressed using a five-point Likert scale. The analysis of these responses did not reveal sufficient agreement so as to identify those items which could be retained as measures of the affective response of nurses towards the certain organisational issues. Consequently, the Likert scale approach was abandoned in favour of the visual analogue scale.

Validity and Reliability of the Climate Questionnaire

The literature suggests that climate is firmly rooted to the situation in which it is measured and although some components of climate might be considered as being universal the diversity of organisational situations in which climate can be measured may mitigate against a single climate instrument which has application in all organisational settings. This is the clearly the view of

Muchinsky(1976), who proposed that components of climate are best defined in terms of what is appropriate to the situation being studied.

Previous attempts at constructing a climate instrument confirm that reliability and validity have been issues of concern. For example, problems of reliability were encountered in studies using the Lickert and Singer(1968) climate instrument. Furthermore, earlier studies using climate, such as Sims and Lafollette(1976), often involved large sample sizes, which suggests that a sizable number of organisational settings, such as the separate departments and sections within a large organisation, were involved. In these large sample size studies the degree of variation in organisational characteristics likely to be encountered further suggest that it may prove difficult to accurately reflect all of these using a single climate instrument.

In the absence of a suitable existing instrument, the purpose of developing a climate questionnaire for use in this study is to explore, from a descriptive perspective, certain selected organisational features along with any associations between these and standards of nursing care. Furthermore, the sample of nurses participating in this study is likely to be relatively small, since only those involved with depot adminsitration clinics will be invited to participate.

As such, the climate questionnaire will be considered as being valid only for use in this study, in that it is designed specifically to

gather data appropriate to the research questions. Since it is not anticipated that the climate questionnaire will have any application outwith the confines of this study, such as by the wider research community, the data collected will not be subjected to reliability and validity analysis.

Pilot Study

To pilot the collection of these data a depot drug clinic in a local Health Centre was selected. This setting was not subsequently used in the main study. The pilot study involved using the observation schedule of the Index, and the nurse, setting and patient information schedules, during 15 contacts involving the administration of a depot drug injection. No amendments to the nurse, patient or setting data collection instruments were required other than the order in which they were attached to the Index.

No deletions from the Index criteria were made. Although the Index had originally been constructed in a format of an observation schedule it was quickly identified that the layout should be substantially condensed to a single A4 sheet to avoid undue, and possibly distracting, manipulation of paper and unnecessary movement by the researcher. Recording the durations of contacts was successfully achieved by using a small hand-held watch which could be operated without being visible to either nurse or patient.

The pilot study also confirmed the earlier suggestion, in relation to the selection of the sample of contacts, that although an appointments system operated times were flexible so that patients might attend at any time during the session and that some might fail to attend. This supports the conclusion that arranging to observe named patients would indeed have proved impractical and inefficient.

During the pilot observations it also became clear that the position of the researcher in the room, the layout of the room, the positions of both the nurse and patient and any use of screens, could all obstruct the direct observation of the actual injection itself. As a result it was anticipated that the nursing examination of the injection site, one of the Index criteria, would most probably occur immediately prior giving to the injection and therefore might not easily be observed by the researcher. Similarly the researcher might not always have been able to confirm the dosage of drug prepared by the nurse.

For these Index criteria the non-participant role adopted by the researcher did not permit the level of involvement that would have been required to confirm the drug dosage in the syringe, while the physical characteristics of settings might not guarantee direct observation of the actual injection or the assessment of the state of the injection site. For ethical reasons, the researcher also wished to protect the privacy and dignity of patients as far as possible and elected not to insist on observing patients in a state of undress.

As a result of experience gained during the pilot study some assumptions regarding nursing practice were made. It was assumed that; the prescribed dose of depot drug was administered by the nurse, and that immediately prior to the injection the nurse would ascertain that the proposed injection site was in a fit state to receive the injection, and that the injection would then be administered in the most appropriate site. These assumptions meant that a score of four would be achieved by a nurse giving a depot drug injection.

The completed climate questionnaire was administered to a group of 10 nurses, including the nurse observed during the pilot study, to assess any problems of administration. Apart from minor typographical errors no problems of note were encountered. The questionnaire was administered to each nurse, by the researcher, immediately after the conclusion of observations of that nurse. This eliminated any response rate problems and avoided any further demands on the nurses time after the completion of observations.

Observational Data Collection Procedure

The pilot study also allowed a procedure for the observing contacts to be established. Prior to the each observation the nurse was asked to introduce the researcher. Thereafter the patient, in the presence of the nurse, was informed about the purpose of the study, that the researcher wished to ask some questions and remain present while the injection was given. Patient were advised of their right of refusal. On consent being given the researcher asked the series of patient

related questions before handing over to the nurse, after which timing of the contact began.

Nurses were asked, as far as possible, not to involve the researcher during the contact and not to seek an opinion or comment from the researcher, unless to ignore the presence of the researcher would have been inappropriate in a social context or might in some way have distressed the patient. When invited to respond the researcher made the minimum contribution appropriate to the circumstances and refrained from any comment on matters relevant to any of the Index criteria by referring the patient to the nurse. Such events proved rare and tended to involve normal social intercourse, such as discussing the weather, which in most cases occurred during the administration of the patient questions.

During each contact the researcher made field notes describing the major components of the contact. Of particular interest were the modes of address used between the nurse and patient, the topics of conversation raised and the extent to which the nurse initiated or responded to these topics. Any physical nursing interventions were described along with any other events such as interruptions.

After the patient had left the room the duration of the contact was recorded and the nurse was invited to summarise any issues of concern. As described earlier, where these comments indicated that an Index criteria had been a factor but had not been identified by the researcher a score was awarded. For example after several contacts nurses indicated that they had assessed the patients

personal hygiene although they had not specifically mentioned this issue directly during the contact. The comments of nurses were documented in the field notes made during the contact. The complete Index, the attached nurse, setting and patient information recording forms, are contained in Appendix A.

Categorisation of Contacts

As described earlier the field notes were used to document the content of the contacts observed. In particular the flow and content of conversation between nurse and patient, any non-verbal nursing interventions or any other notable events were recorded. These field notes were later coded by three nurse experts in order to describe the nature of each contact by the allocation of a series of categories. The categories used were descriptive and carry no numerical value.

Raters were instructed to consider the description of each contact and then to identify which of the following categories adequately summarised an aspect of the contact, as documented in the field notes. A contact could be therefore be described in terms of one or all the categories noted below, as they are not mutually exclusive.

Basic Contact

The contact description contains elements primarily related to the administration of the depot drug injection. Every contact will therefore meet this definition in that an injection being given is a requirement for inclusion in the study.

Social Contact

The contact description contains elements of personal social intercourse; such as the use of christian names or non-clinical conversation topics.

Structured Contact

The contact description contains elements which indicates that the nurse used the contact to explore certain issues or to gather any relevant information.

Directive Contact

The contact description indicates that the nurse initiated or reviewed some form of nursing intervention, gave specific direction to the patient, or took some other form of action in response to particular circumstances.

Exclusions

Failure to obtain the consent of either patient or nurse concerned excluded that contact from the study. It had also become apparent that some CPNs might also administer injections during home visits, although the numbers of these were minimal compared with clinic attendances. For these home injections the arrangements in terms of appointment times were likely to be imprecise or flexible in response to the general workload demands of nurses and the

practicalities of travelling time and traffic. In view of these practical concerns, and the part-time availability of the researcher, contacts where depot injections were given during home visits were excluded from the study.

Ethical Considerations

This investigation involved observing and describing current nursing practice in settings where depot drug injections were routinely administered to out-patients. There was no requirement for nurses to conduct any specific nursing interventions as a consequence of participation in the study, other than to administer the depot drug injections which would be given in any event. While the study had no implications in terms of changing nursing practice, the issues of confidentiality, consent and privacy were pertinent ethical considerations.

Consent from all nurses and patients was requested and required, and only where consent was received were data collected. In obtaining consent all subjects were informed of the purpose of the study and that their anonymity was assured. Patients were informed before each contact that the researcher wished to ask some questions and be present during the time spent with the nurse. Each patient was reminded of their right to refuse to participate. The consent of patients was always obtained in the presence of the nurse. Patients were automatically excluded from the study where they refused, or appeared unable, to give consent. Some patients were also excluded where the nurse indicated any doubt regarding the ability of the

patient to give valid consent, or where the nurse advised that participation would be inappropriate or might cause distress.

Since both questioning and observation were employed, the issue of privacy was particularly important. In respect of questions, the information given to obtain consent did indicate that questions would be asked, and also that the patient had a right to refuse to answer any specific questions. In order to further maintain the privacy and dignity of patients, the researcher did not deliberately seek to observe patients while they were a state of undress. In any event, as described earlier, it was probable that direct observation of the injection would be impractical. Consequently, and in order to provide patients with as much privacy as the layout of settings permitted, the researcher made no attempt to deliberately secure a position of observation where injections could be directly observed. Nurses were therefore advised that they were free to use any available screening.

CHAPTER FIVE

Main Study Area, Nurses, Patients and Settings

In this chapter findings regarding the arrangements for depot drug delivery within the main study area, and the characteristics of nurses, patients and settings involved, are presented. The choice of statistical techniques used for the analysis of data was dependent on the nature of the data collected and the research questions.

Since the key numeric variables were not normally distributed then non-parametric, or distribution free, statistical tests were used in the analysis. The Chi-Square test was applied in the case of nominally measured data. For data at the ordinal level of measurement the following tests were applied. The Kruskall and Wallis one-way analysis of variance by ranks was applied for the analysis of more than two independent samples, the Mann-Whitney test for the analysis of two independent samples, and the Spearman rank-order correlation coefficient.

The null hypothesis of no difference or association was rejected if the significance level of the results of a statistical analysis was 5 percent or less. Where the result of a test was statistically significant the test statistic and the level of significance is given.

Managerial Arrangements

The description of settings used to administer depot drugs involved detailing the managerial arrangements within the main study area. This is aided by defining three operational types of both clinic settings and grades of CPN. The clinic settings studied were

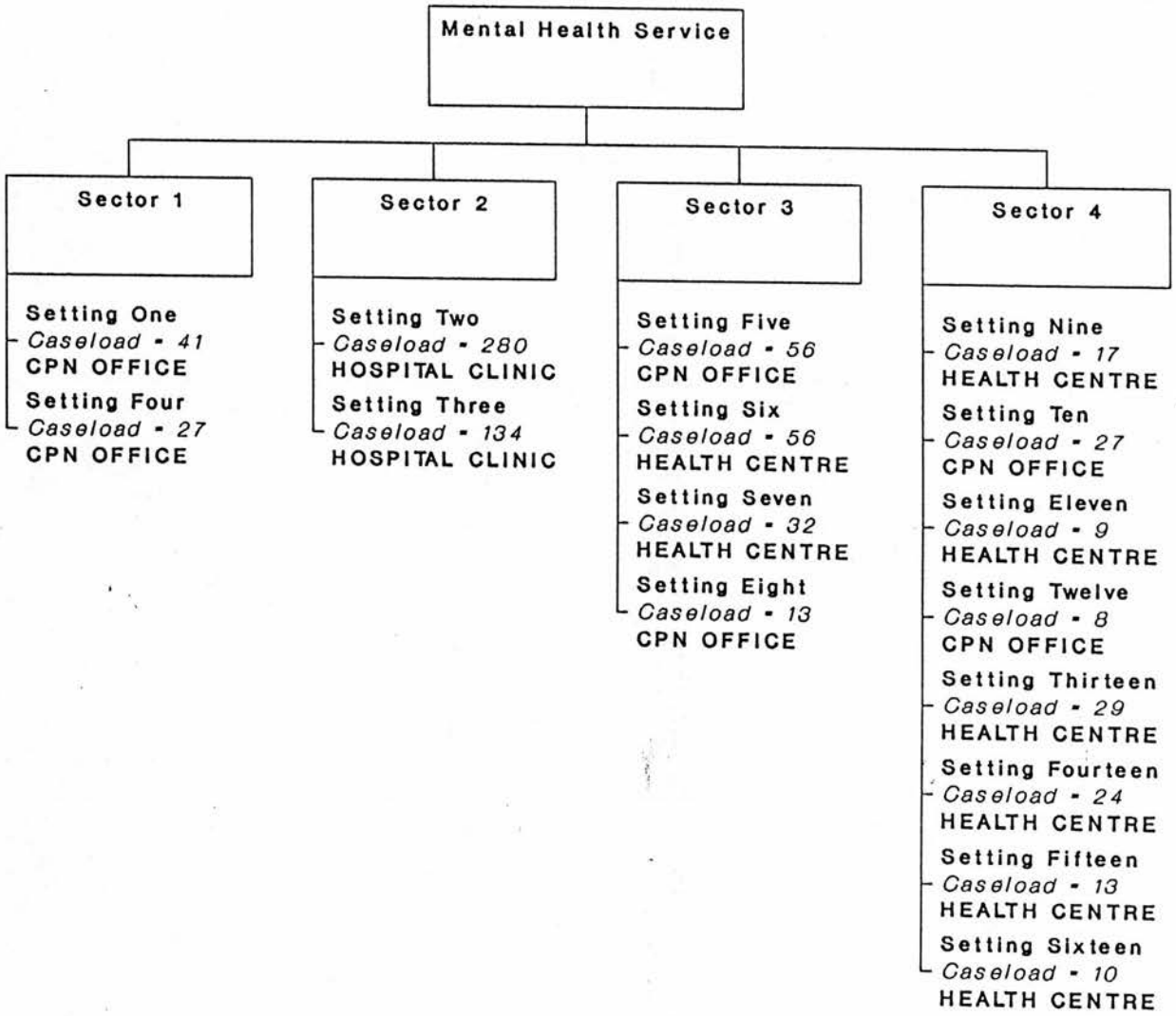
identified in consultation with local nurse managers during the access negotiations. All but two of the settings identified were used to collect data during the main study. The exceptions were a setting where the CPN concerned declined to participate and the setting in which the pilot study took place.

The main study area comprised the mental health services of a Scottish Health Board. These services were organised as a single managerial unit that was further devolved into four Managerial Sectors defined by geographical boundaries. Each of the four sectors catered for a similar size of population and each had separate managerial arrangements, including nursing management. Services in each sector were based in a major hospital site and included the CPN departments dealing with depot drug clinics. Although some CPNs were wholly or partly located in accommodation outwith the major hospital sites the nurse managers responsible for CPN services were based in these hospitals.

Types of Depot Drug Setting

Sixteen of the depot drug settings identified during the access negotiations were used to collect data during the main study. Each of these settings was considered as being one of three distinct types. Figure 1 shows the number and type of settings within each of the four sectors, including the caseload size of each setting.

FIGURE 1
Settings in Managerial Sectors



Hospital Clinics

The two hospital clinics were situated in the same sector. One was located in the main mental illness hospital and the other in an major acute hospital in which a satellite mental illness service was managed from the nearby mental illness hospital. The setting in the acute hospital was spacious and well equipped and doubled as the personal office of the CPN concerned. The other hospital clinic was located in a small treatment room in the out-patient department of the mental illness hospital. In both these settings Consultant Psychiatrists held clinics which were run concurrently with depot drug injection sessions, often involving the same patients.

CPN Offices

The term CPN office is used to identify those community located settings used for depot drug administration other than those based in health centres. These settings all had a primary use as District Nursing and Health Visitor bases to which CPNs had negotiated access. All were located in established population centres, mostly comprising of local authority housing stock, where there was no multi-purpose health centre in close proximity. In some CPN offices the rooms in which depot drug injections were given were sparsely equipped and furnished compared with the health centre settings. There were commonly posters giving information about pregnancy and child care. Portable screening was used in some settings and medical staff were not usually available.

Health Centres

Eight of the 16 settings were located within local multi-purpose health centres. These settings were primarily used for GP consulting and associated nursing services, such as changing dressings, family planning, and health screening. CPNs had gained access to these health centres in order to conduct depot clinics. The rooms used all had fitted screens although, like CPN offices, the range of posters on display indicated that these facilities were most often used for nursing mothers and children. Hospital Consultant staff were not available but there did appear to be a close relationship between CPNs and the GPs based in these health centres, many of whom referred patients for depot drug administration.

Depot Drug Settings in Managerial Sectors

Settings in Managerial Sector One

Of the three settings located in this sector one was used in the pilot study and was therefore excluded from the main study. The two remaining settings were both CPN offices. Setting One was particularly spartan in terms of furnishing and decor but was situated conveniently close to a large local authority housing estate. Setting Four was larger and appeared to be more heavily used by Health Visitors and District Nurses, and had better decor and furnishings than Setting One. It was also conveniently situated for local population access.

Settings in Managerial Sector Two

Both the settings located in this sector were the only hospital clinics within the main study area. Setting Two was situated in the grounds of a large acute hospital and had a caseload of 280 patients. This caseload included patients attending an additional clinic which dealt with the administration of other psychiatric drugs. Setting Three was located in the main mental illness hospital and patients were seen in a small treatment room within the out-patient facilities.

In both these settings Consultant Psychiatrists ran clinics concurrently with depot drug sessions and often saw the patients attending for injection. Medical Staff were therefore immediately available to discuss the care of a particular patient. Within this sector a further depot drug clinic was situated in a local health centre some distance from the major hospital. However, the CPN in this setting declined to participate in the study.

Settings in Managerial Sector Three

The settings in Sector Three were all located in local population centres. These settings were more distant from the main hospital than in the other sectors because of the location of this hospital at the periphery of the catchment area of the sector. Of the four settings two were based in health centres and the remaining two in CPN offices.

Facilities in both the health centre settings were good. The larger of the two CPN offices was located centrally in a large local authority housing estate and the other in a less busy clinic serving a smaller population centre. One of the CPN offices was particularly unsuitable in that injections were given in a cloakroom adjacent to a lavatory.

Settings in Managerial Sector Four

The most notable feature of Sector Four is the number of settings used for depot drug administration and the emphasis on health centres facilities. While each sector catered for a similar population, Sector Four accounted for eight of the 16 settings studied and contained all but two of the eight health centre settings. The two remaining settings were CPN offices. In one of the health centre settings the CPN concerned was in the habit of playing music cassettes during patient contacts.

Qualifications of Nurses

For the purposes of this study nurses were allocated to one of three grades depending upon whether they were primarily hospital or community based and whether or not they held a recognised Community Psychiatric Nursing post-basic qualification. All the nurses participating in the study were Registered Mental Nurses. The grades of CPN One, CPN Two and CPN Three were used to denote aspects of qualification and are not intended to imply any form of seniority or a particular fitness to deal with the needs of depot drug patients.

CPN One Nurses

Nurses designated as CPN One were all based in the CPN department but had not obtained post-basic qualification in this specialty.

CPN Two Nurses

Nurses designated as CPN Two were also based in a CPN department but had obtained a recognised post-basic qualification.

CPN Three Nurses

These nurses, while having links with the CPN department, were observed in the hospital clinic settings. Neither held a Community Psychiatric Nursing post-basic qualification.

Of the 17 nurses observed 10 were CPNs with post-basic qualification (CPN Two), five were CPN department attached nurses with no post-basic qualification(CPN One), with the remaining two nurses being based in the hospital clinics(CPN Three).

Appointment Arrangements in Depot Drug Settings

The appointment arrangements were broadly similar in all 16 settings and the use of appointment cards was universal. However, there were occasions where the CPN had run out of cards and patients would lose or forget their own. The majority of appointment cards were supplied by depot drug manufacturers and had the name of a particular drug prominently displayed. There were several occasions when patients

were given an appointment card where the drug named on the card was not that prescribed for them. On one of these occasions a CPN had to spend some time reassuring a patient that their prescribed drug had not been changed because they had been given an appointment card with the name of a different drug.

The nurses reported that, with the exception of annual leave and staff sickness, patients could expect to see a particular CPN when attending for injection. During a number a contacts nurses informed patients when they would be on annual leave and usually told the patient which CPN would give them their injection when they next attended. The use of specific appointment times was observed, primarily in those settings within Sector Four where the caseload numbers tended to be smaller.

In practice the timings of appointments were flexible and on occasions there would be a gap between the departure of one patient and the arrival of the next. In Sector Four settings a queue of patients awaiting injection rarely developed but in the other sectors patients would arrive at any time during the clinic and queuing was observed at the beginning and end of clinic sessions.

Nursing Records used in Depot Drug Settings

Apart from prescription and drug recording sheets and appointment cards the most common record was the diary. In the diary the CPN would tick off each patient as they attended and would enter their name against the next due date. They would then amend the patients

appointment card to record the next injection date. Some nurses also recorded in the diary which injection site they intended to use next time, and in some cases the drug and dosage was also recorded.

Nurses also completed other written records using a variety of formats. The term Care Plan proved particularly difficult to interpret. Some of those nurses who stated they used care plans did not have them available or appeared to use this term to describe their personal written notes or a kardex type of record. One CPN clearly interpreted the term care plan to mean that she knew what the patients problems were and, therefore, she had a plan to account for these. As a consequence the collection of data regarding the type of nursing records used must be regarded as incomplete since some records claimed to be in use were not available during data collection.

During the observation period most nurses commented on a standardised care plan which was to be instituted by nurse managers in all four sectors. Some nurses described having a target number of 'patient profiles' to prepare for the new care plans before a prescribed date. While there was support for the principal of improving care plans some CPNs held the view that the new format was primarily orientated towards hospital in-patients and was being implemented for managerial reasons rather than clinical need. The new care plans were not available at any time during the collection of data.

Exclusively within Sector Four a computer based record, known as GEPAS, was in use. GEPAS was used only in relation to patients referred by Consultant Psychiatrists and was not used for patients referred by GP's. This system was developed by a hospital based Consultant Psychiatrist. An information sheet was provided for each patient and was forwarded to the CPN prior to the injection due date. Nurses had been trained to conduct a series of examinations to assess drug side-effects and record the results on the information sheet. Other relevant information, such as whether the patient had failed to attend, was also recorded.

The GEPAS information sheets were then sent for data-processing and the information was added to the patient's record. The updated record would then be routinely re-submitted to the nurses before the next depot drug contact. Although primarily related to the assessment of drug side-effects, which the CPNs were obviously well placed to do, and containing no singularly nursing components, the actions taken by the observed nurses in relation to GEPAS proved to be an important factor in the variation in care scores.

Caseload Sizes: Settings and Nurses

Caseload sizes provide some indication of the workload demanded of both settings and nurses. The caseload sizes of settings consisted exclusively of depot drug attenders with the exception of Setting Three, a hospital clinic, where a clinic dealing with the monitoring of other drugs was also situated. The formal caseloads of CPNs included patients who did not receive depot drugs. To establish the

extent to which each CPN was involved in depot drug administration the number of depot drug receivers seen from within the formal caseload was established. In addition the numbers of patients seen for depot drug administration but who were not part of the formal caseload was also obtained.

Setting Caseload Sizes

The largest caseload sizes, of 280 and 134, were found in the two hospital clinics in Sector Two. The larger of these was Setting Three which included those patients attending for the monitoring of other drugs associated with the treatment of mental illness. Both the hospital clinics had concurrent Consultant clinics which often involved those patients who were attending for depot drugs. This practice only occurred in the two hospital clinics.

The remaining 14 settings had caseload sizes of between 8 and 56 depot drug patients. The mean caseload size of CPN offices and health centres were 28.67 patients and 23.75 patients respectively. The majority of health centres were located in Sector Four, which had proportionately the most depot drug settings in terms of the population served. Caseloads were lower in health centre settings.

Excluding the hospital clinics the setting caseloads of the remaining three sectors were variable. In Sector One the mean setting caseload was 34 patients; in Sector Three 39.25 patients and in Sector Four 17.13 patients. The caseload sizes in Sector Four were significantly lower ($KW = 9.16$ $p = <0.05$) and this is clearly

because of the greater number of alternative settings. This variation in caseload size also had consequences regarding the numbers of contacts observed during each depot drug administration session. The study method used involved observing all the scheduled contacts during a drug administration session. Since settings with larger caseloads were required to schedule more contacts during each session, in order to meet the demand for depot drug administration, more contacts were observed in these settings.

Nurse Caseload Sizes

The formal caseload of CPNs comprises those patients for whom they are the designated responsible nurse. However, CPNs who conduct depot drug clinics may also give injections to patients who are not formally their responsibility. These informal contacts mainly occurred because the responsible CPN did not participate in a depot clinic and so referred these patients to a colleague for their routine injections. In Sector Four, where patients were offered a choice of clinics, this situation could also occur when a patient elected to attend a depot clinic other than that which their 'own' CPN serviced.

Table 1 shows the formal caseload size of nurses, the number of depot drug patients within these formal caseloads, and the number of depot drug patients seen informally. The percentage of depot drug attenders is shown in relation to the the total number of patients seen.

TABLE 1: Nurse Caseload Size and Number of Patients Seen

NURSE	CPN TYPE	FORMAL CASELOAD SIZE	DEPOTS IN FORMAL CASELOAD	INFORMAL DEPOT PATIENTS	TOTAL DEPOT PATIENTS	% SEEN RECEIVING DEPOT
1	1	42	15	26	41	60.29
2	3	280	130	0	130	46.43
3	3	134	134	20	154	100.00
4	1	59	52	5	57	89.06
5	2	92	43	25	68	58.12
6	2	101	56	0	56	55.45
7	1	66	23	5	28	39.44
8	2	44	19	3	21	43.18
9	2	45	20	3	23	47.92
10	2	58	28	5	33	52.38
11	2	65	17	4	21	30.43
12	2	52	30	16	46	67.65
13	2	72	19	6	25	32.05
14	1	90	13	3	16	17.20
15	1	20	1	70	71	78.89
16	2	55	28	3	28	53.45
17	2	57	30	30	60	68.97

The formal caseloads of nurses are variable throughout the main study area. It can be seen that the two highest caseloads are attributable to both the hospital clinic nurses. The mean formal caseload sizes of the remaining two groups of nurses are similar and are not significantly different, at 55.40 patients for CPN One nurses and 64.10 patients CPN Two nurses. The number of depot drug patients seen by each CPN is also variable, with 15 of the 17 nurses administering depot drug injections to informal patients outwith their formal caseloads.

For 10 of the 17 nurses over half of all the patients regularly seen received depot drugs. Six of the 17 nurses appeared to deal with considerably more informal patients than did the remaining nurses, which may indicate that they, in particular, were providing an injection giving service for their colleagues. This is illustrated

in the case of Nurse 15, who had the smallest formal caseload of 20 which contained only a single formal depot drug attender but who administered depot drugs to a further 70 patients who were allocated to the formal caseloads of other CPNs.

Of the 202 contacts 45(22.28%) were informal, and twenty-five of these occurring in Sector Four where patients were allowed to select the depot drug clinic they preferred to attend irrespective of whether or not they were part of the formal caseload of the CPN conducting that clinic. The field notes show that during these informal contacts nurses often had to suggest that the patient refer a particular matter to their 'own' CPN.

Therefore, the administration of depot drugs represents a sizable proportion of all patient contacts for many of these nurses. For some the numbers of patients seen for injection, not all of whom were allocated to their formal caseload, is such that depot drug administration might be the most frequent reason for contacts with some patients.

Characteristics of Patients

Of the 202 contacts, 123(60.89%) were with male patients and 79(39.11%) with female patients. Male patients also accounted for the majority of contacts in each of the groups within the sample. No statistically significant differences were found regarding gender between the sectors, types of setting, or grades of CPN.

The mean age of all patients was 43.18 years (sd 11.88), with ages ranging from 18 - 70 years. Male patients had a mean age of 41.22 years (sd 41.22) and female patients 46.23 years (sd 11.26). For both sexes the range of ages were similar; 20 - 70 years for males and 18 - 69 years for females. The difference in ages between the sexes was statistically significant (U = 3558 p =<0.02), with male depot drug receivers being younger than females. The ages of depot drug receivers were not significantly different between sectors.

Frequency of Injection

Table 2 shows the injection administration intervals. Sixteen(7.92%) contacts involved weekly drug administrations; 103(50.99%) were fortnightly; 33(16.34%) three weekly, and 50(24.75%) were four weekly or at longer intervals. The mean drug injection frequency was every 2.56 weeks (sd 0.99).

Table 2: Depot Drug Administration Intervals

Injection Frequency	Sex		Sectors				Nurses			Settings		
	M	F	1	2	3	4	1	2	3	1	2	3
Weekly	11	5	7	0	5	4	11	5	0	0	9	7
2 Weekly	64	39	20	17	31	35	32	54	17	17	41	45
3 Weekly	18	15	5	5	9	14	8	20	5	5	13	15
4 Weeks +	30	20	5	9	12	24	9	32	9	9	12	29

In terms of the various groups shown in Table 2 there were no significant differences in the drug injection intervals involving the gender of patients, type of setting, or sector. There were, however, significant differences in injection frequency contacts between the grades of nurse (Chi-Square = 16.38, p = <0.02).

This significant finding appears related to the CPN One nurses contacts having the lowest mean injection frequency interval of 2.25 weeks, compared with 2.75 weeks for CPN Two nurses and 2.74 weeks for CPN Three nurses. Table 2 also shows that CPN One nurses accounted for most of the contacts involving weekly injections and had proportionately fewer contacts involving administration intervals greater than fortnightly. For example, 18.33 percent of CPN One contacts involved weekly drug administrations, compared to only 4.50 percent of CPN Two contacts and none by CPN Three nurses.

Oral Drug Usage

One objective of the questioning of patients was to determine if they were currently receiving any oral medication. This information was necessary in order to determine whether or not it would be relevant for the nurses to monitor compliance with oral drugs during contacts. All those who were receiving oral drugs were able to give either the specific details of the drug and dosage, or a reason for the drug being used. This information allowed the oral drug regimes reported by patients to be categorised as being either anti-parkinsonian drugs, drugs commonly related to mental health care, or other 'non-psychiatric' drugs.

Of the 202 contacts, 93(46.04%) involved patients who were concurrently receiving some form of oral anti-parkinsonian drug. No significant difference in the frequency of anti-parkinsonian drug administration between any of the groups within the sample was found.

Some 79(39.11%) contacts involved patients receiving concurrent administration of drugs associated with mental health care, most commonly major tranquillisers (eg. Chlorpromazine) and anti-depressants (eg. Amitryptiline). There were significant differences in the numbers of patients receiving these drugs between sectors (Chi-Square = 25.23, p = <0.001), perhaps suggesting different medical prescribing practices. Analysis showed that less than half of the contacts observed in Sectors One, Two and Four used concurrent oral anti-psychotic drugs, while in Sector Three the majority (63.16%) of contacts involved patients receiving oral anti-psychotic drugs. In 30(14.85%) contacts patients said they were taking an oral 'non-psychiatric' drug, such as an analgesic.

Patients Living Alone and Community Supports

An important aim of this study was to explore the extent to which nurses utilised depot drug contacts. As was proposed earlier the regular contacts involving depot drug administration may represent the only contacts these patients have with mental health care services whilst living in the community. For those patients living alone these contacts may have additional importance in terms of an opportunity for social intercourse. It was therefore considered of value to identify the extent to which the contact with nurses might represent an important event for patients, particularly those living alone.

Of the 201 contacts where patients responded to this question 74(36.63%) involved patients who lived alone. The numbers of contacts involving patients either living with others or living alone were not significantly different between the sexes. Patients were also asked to identify their most important community supports. The results indicate that family members were the most common source of support. Parents or siblings were cited in 112(55.45%) contacts and spouses, children or other relatives during 37(18.32%) contacts. Friends or care staff were cited during 52(25.87%) contacts.

Statistically significant differences in the sources of community support were revealed between the gender of patients and in relation to whether or not patients lived alone. Of the 123 male contacts 79(64.23%) identified parents or siblings as being the most important community support compared with 33(41.77%) of the 79 female patients. Females more often identified a spouse, child or other relative than did male contacts; 25(31.65%) of 79 female contacts compared with 12(9.76%) of 123 male contacts (Chi-Square = 16.96, $p = <0.01$). The tendency of males to cite parents and siblings is perhaps a consequence of the finding that male patients were younger and more commonly lived with others.

The difference in important community supports was also statistically significant between clients who lived alone and those who lived with others (Chi-Square = 36.33, $p= <0.001$). Eighty-seven(67.97%) of the 128 contacts involving living with others identified parents or siblings compared with 25(33.78%) of

the 74 contacts where the clients lived alone. Thirty-seven(50.00%) of the 74 contacts where clients lived alone identified friends or care staff compared with 15(11.72%) of the 128 contacts where clients lived with others.

Those clients who lived alone, particularly females, had less reliance on family supports and therefore were more reliant on the support of friends and care staff. Patients who lived with others were mainly supported by their families, and predominantly by the parents and siblings with whom many of these patients lived.

CHAPTER SIX

Standards of Nursing Care

As described in the Study Design and Methods chapter an observation schedule was developed from the Criterion Referenced Index and was used to record the standard of nursing care observed during depot drug administration contacts. This allowed a care score to be allocated to each contact. A care score of four could be obtained by a nurse just giving a depot drug injection. Higher care scores indicate that nursing interventions additional to injection giving were noted.

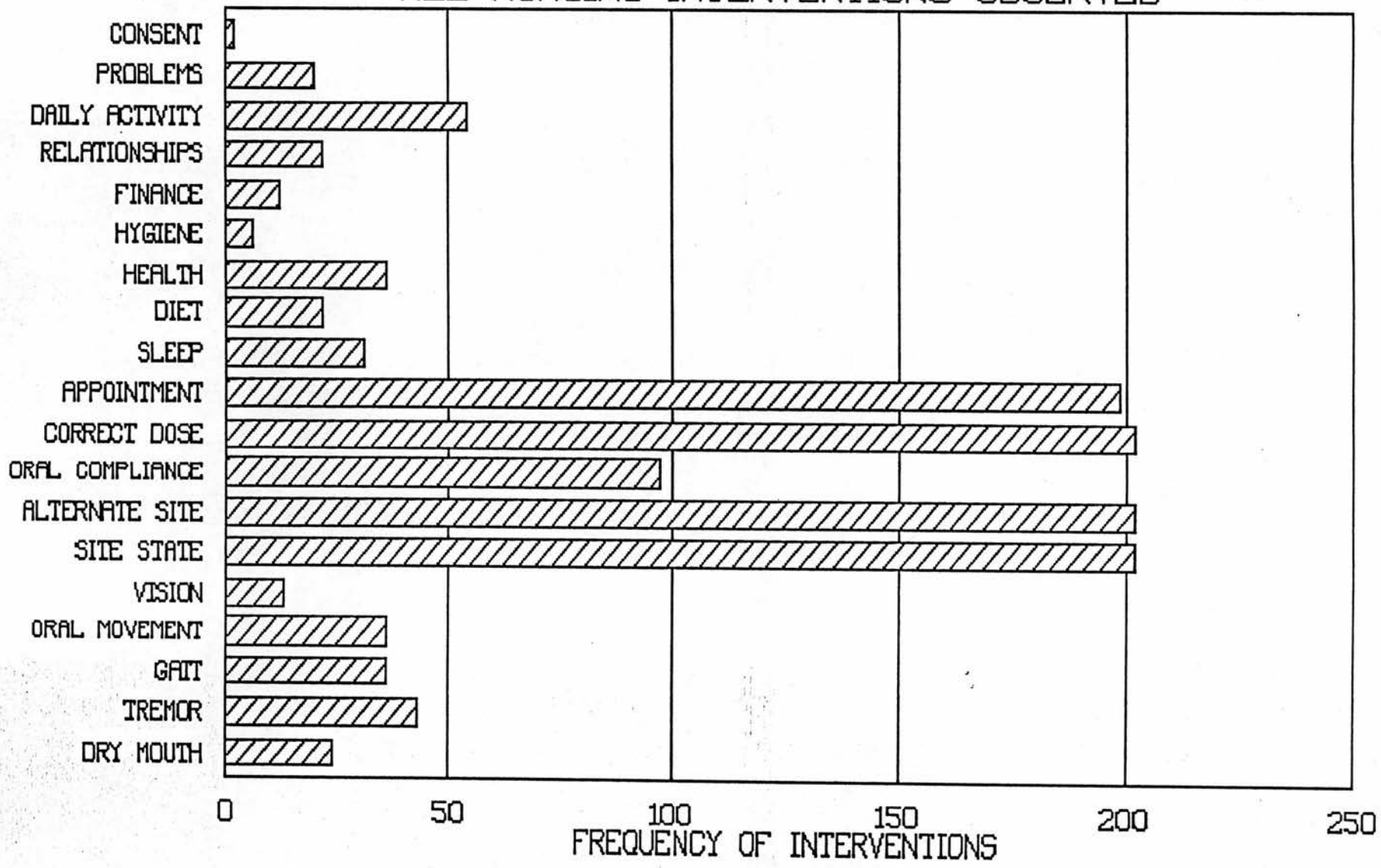
Nursing Interventions and Care Scores

During the 202 contacts observed a total of 1259 nursing interventions occurred(Figure 2). Of these 606(48.13%) were the three interventions involving the administration of an injection which were deemed to have occurred during all contacts. A further 199(15.81%) interventions involved the nurse confirming the date of the next appointment. During three of the 202 observed contacts nurses failed to confirm the next appointment date.

The three interventions involving injection giving; examination of the injection site, using the most appropriate injection site, and giving the correct drug and dosage, together with arranging the appointment for the next injection, represent the practical aspects of administering injections. These account for 805(63.94%) of the 1259 nursing interventions detected and were categorised as 'injection' interventions. Figure 3 shows the composition of the injection category of interventions.

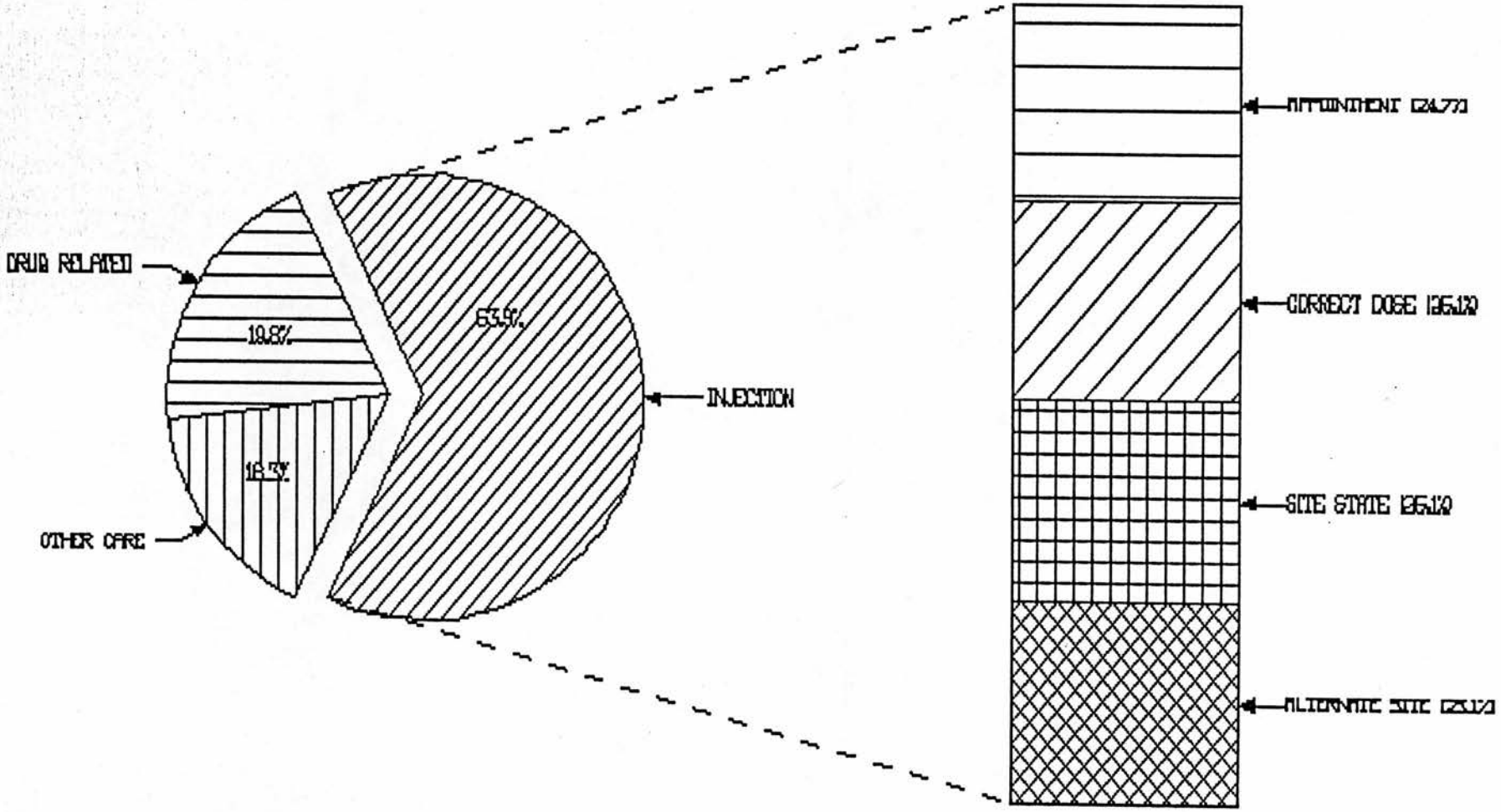
FIGURE 2.

ALL NURSING INTERVENTIONS OBSERVED



N = 202 CONTACTS: 1259 INTERVENTIONS - MEAN 6.23 PER CONTACT

FIGURE 3.
COMPOSITION OF 'INJECTION' INTERVENTIONS



N = 805 INTERVENTIONS

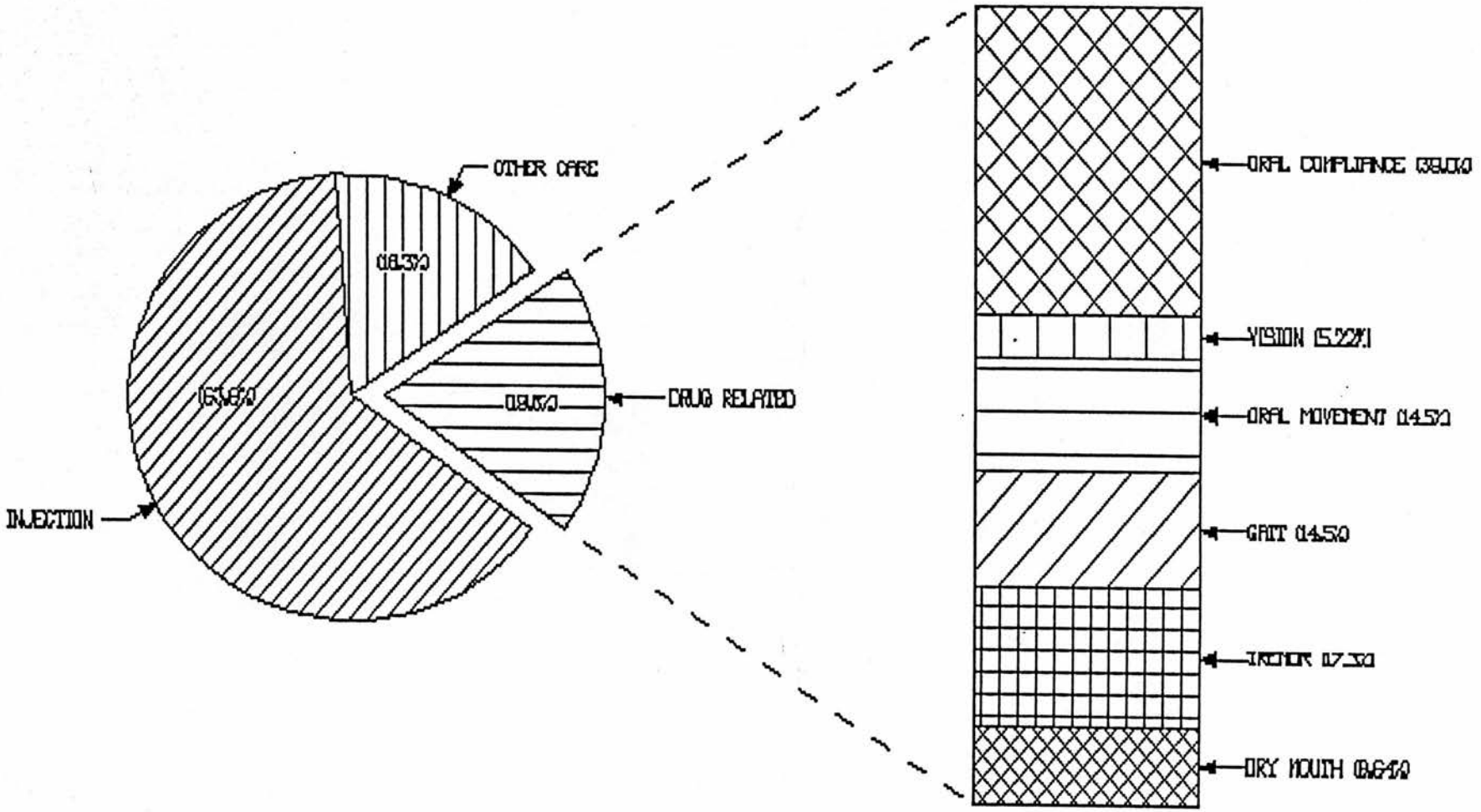
The five interventions involving the monitoring of drug side-effects (dry mouth, tremor, gait, oral movement and vision) accounted for a further 152(12.07%) interventions. These tended to occur in combinations and were absent in 146(72.28%) of the 202 contacts. A score for monitoring compliance with oral medicines was awarded during 97(48.02%) contacts. The corollary of this being that in 105(51.98%) of the 202 contacts compliance was not monitored even though the patients concerned were receiving oral drugs. The 249(19.78%) interventions involving the monitoring of both drug side-effects and compliance with oral medicines represent drug related issues other than those involving injection giving. These were categorised as 'drug related' interventions, the composition of which is shown in Figure 4.

Since 1054(83.72%) of the 1259 interventions were accounted for by the injection and drug related categories then the remaining 205(16.28%) reveal the other forms of nursing intervention observed. These were categorised as 'other care' interventions and comprise the remaining nine index criteria of; sleep, diet, general health, hygiene, finance, relationships, daily activities, problems and consent to injection(Figure 5).

As described in the Study Design and Methods chapter some index criteria attracted a care score of two where some form of nursing examination occurred. In addition to the 202 interventions involving the examination of the injection site, which were common to each contact, a further 108 interventions attracted a score of two. All of these involved the monitoring of drug side-effects.

FIGURE 4.

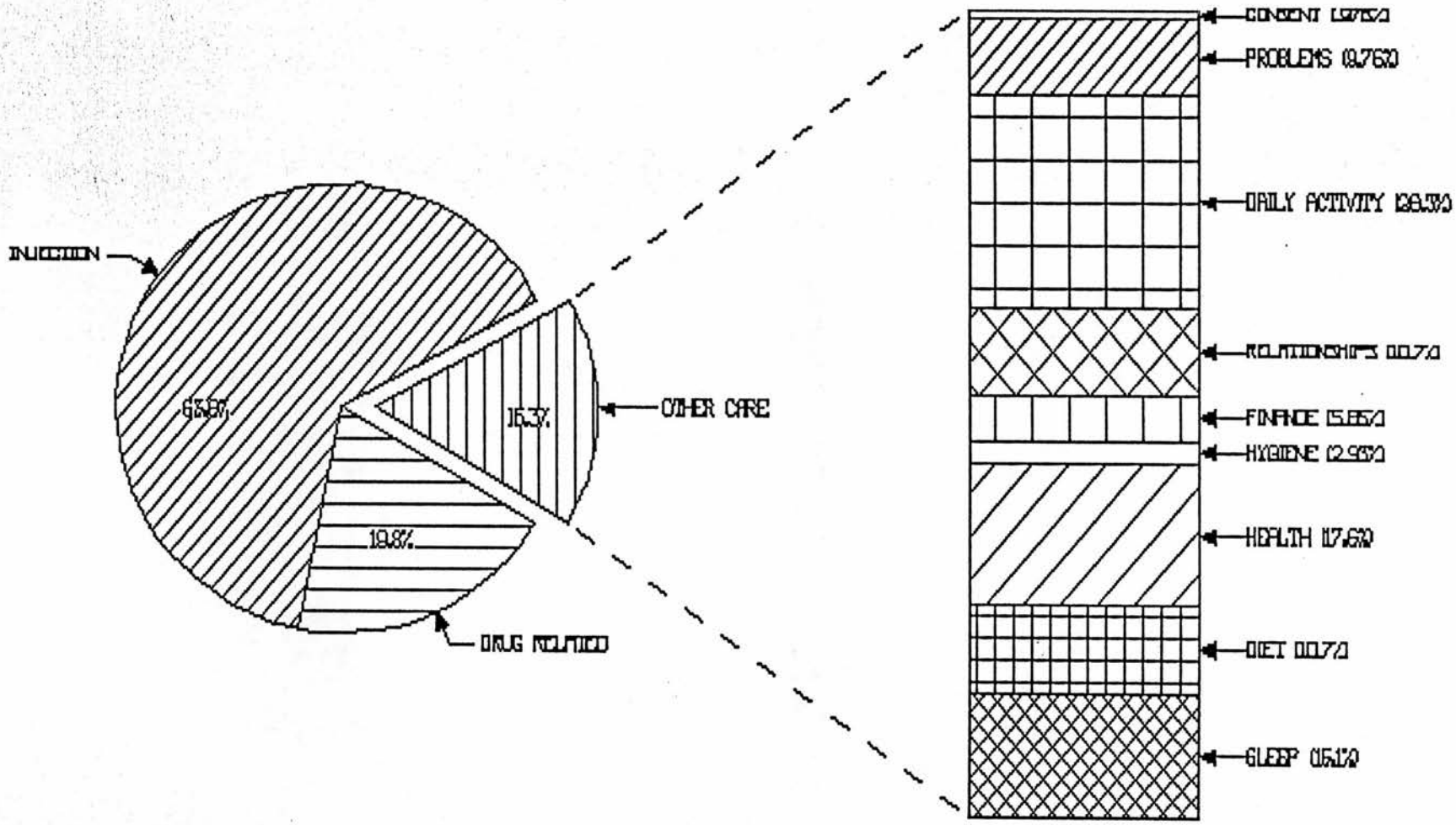
COMPOSITION OF 'DRUG RELATED' INTERVENTIONS



N = 249 INTERVENTIONS

FIGURE 5.

COMPOSITION OF 'OTHER CARE' INTERVENTIONS



N = 205 INTERVENTIONS

A deduction of one was made from the care score of the 105 contacts where compliance with oral medicines was not monitored but the patient concerned was taking a prescribed oral drug (see Study Design and Methods chapter).

The resultant care scores from the 202 observed contacts ranged between four and 17, with a mean score of 7.25 and a mean 6.23 nursing interventions per contact. Forty-five(22.28%) of the 202 contacts only achieved the minimum score of four, indicating that the only nursing interventions observed were those concerned with the administration of an injection.

In order to illuminate differences within and between groups in the sample, and to aid the presentation of findings, the categories of injection, drug related and other care interventions will be used to summarise the nursing care observed. Since the index criteria can be allocated to these three categories it follows that the care score for each contact can also be expressed in the same terms.

Duration of Contacts

The duration of each contact was recorded during observation. A highly significant positive correlation between the care score and contact time was found (RHO = 0.64 p = <0.001). This finding confirms that those contacts with higher care scores, which involved more nursing interventions being observed, were of a longer duration than those with lower care scores where fewer interventions occurred. The only group of contacts where a significant

correlation between care score and time was not found were in the hospital clinics of Sector Two. This finding is discussed later in this chapter.

Significant negative correlations were found between the mean duration of contacts and the caseload size of settings (RHO = -.73 p = <0.001), and between contact duration and the number of observations made in each setting (RHO = -.47 p = <0.05). This indicates that in settings with a larger caseload more injections were scheduled during each depot drug session in order to meet the local demand. Consequently, these contacts tended to be brief. No significant correlation between the number of contacts observed of each nurse and their personal caseload size was found. This suggests that the setting caseload size was the more crucial in terms of the number and duration of depot drug contacts observed and the standards of nursing care given.

The range of contact duration ranged from one to 23 minutes resulting in a mean duration of 4.81 minutes. Of the 202 contacts 23(11.39%) lasted for only one minute. Ninety-seven(48.02%) contacts lasted for three minutes or less, and 151(74.75%) for six minutes or less. The mean duration of contacts is shown in relation to each of the various groups for which data are presented. The data shows that contacts lasting for two minutes or less tended to be wholly orientated around the giving of an injection. Where contact duration extended to three or four minutes the focus remained injection orientated but there was some evidence of other care interventions. Contacts exceeding four minutes continued to focus on injection

giving, along with some other care interventions, but most notably contained increasing evidence of drug related interventions, and in particular the more frequent monitoring of compliance with oral medication. Contacts lasting longer than seven minutes showed a marked increase in the number of interventions dealing with drug side-effects. These longest contacts accounted for 107(70.39%) of the 152 drug side-effects interventions observed.

Standards of Nursing Care and Care Groups

The sample was divided based on the care score in which the 25th, 50th and 75th percentiles occurred. The resultant four care groups were unequal in terms of the numbers of contacts but each group had a defined range of care scores, often involved a similar pattern of interventions. Table 3 shows findings relating to these care groups.

Table 3: Interventions, Mean Care and Mean Duration in Care Groups

	Care Group One	Care Group Two	Care Group Three	Care Group Four
Contacts	76	35	48	43
Mean Interventions per Contact	4.41	5.29	6.67	9.74
Injection Interventions(%)	90.75	75.68	60.00	40.33
Drug Related Interventions(%)	0.30	14.59	18.75	38.42
Other Care Interventions(%)	8.96	9.73	21.25	21.24
Mean Care Score	4.41	6.00	7.63	12.86
Mean Contact Duration(Minutes)	2.93	3.37	5.31	8.74

n = 202

Care Group One

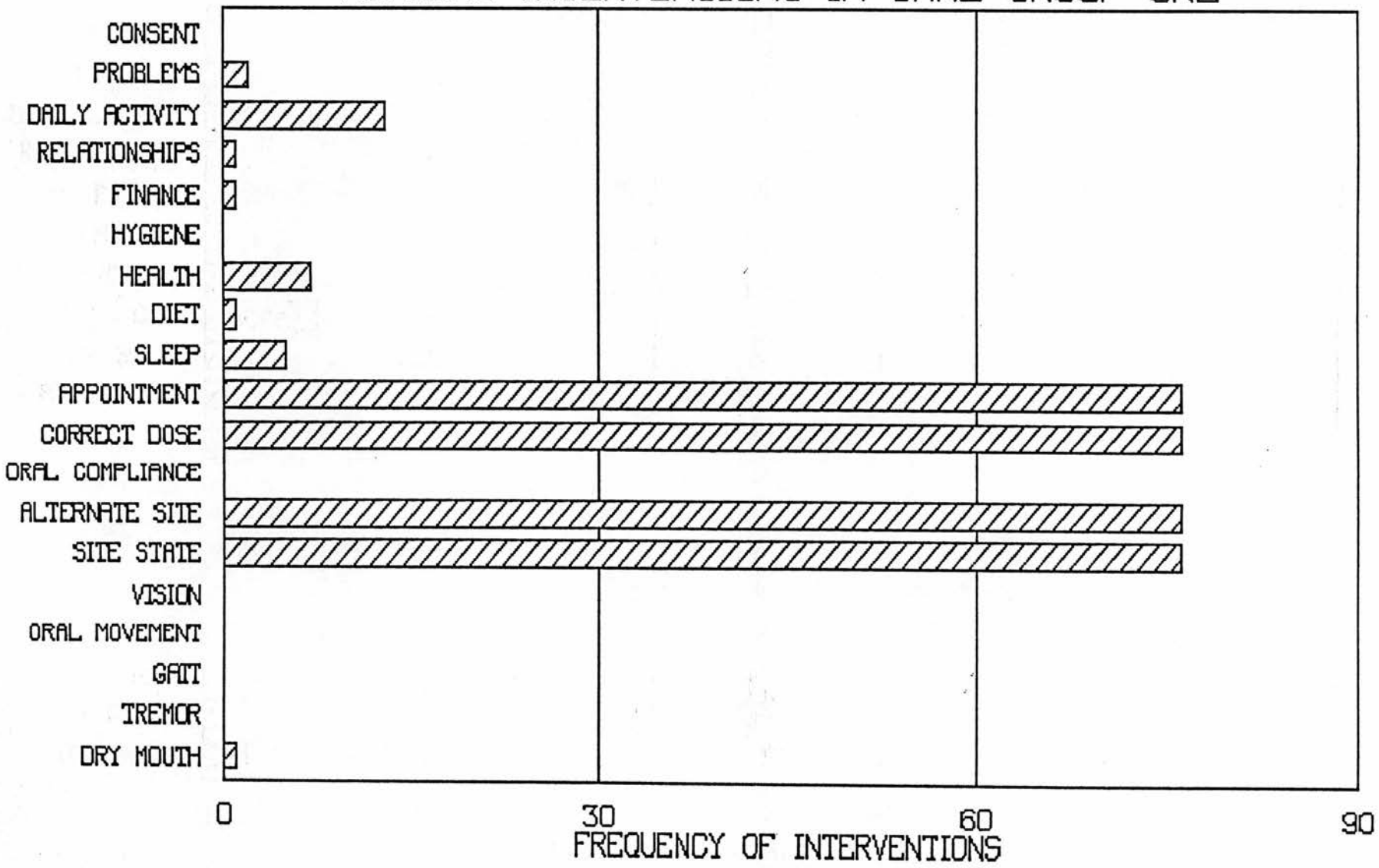
The 76 contacts in Care Group One all had care scores of five or less. These include the 45 contacts with the lowest possible care score of four. A total of 335 interventions were observed of which over 90 percent involved the giving of an injection(Table 3). The frequency of each index criteria observed during these contacts is shown in Figure 6.

In all of these contacts nurses failed to monitor the compliance of patients with prescribed oral medicines, so that a deduction of one was made from the care score of each contact. Apart from a single drug related enquiry nurses made no other efforts to monitor drug side-effects. The remaining 30(8.96%) interventions were of the other care category and comprised of enquiries regarding; daily activities(13), general health(7), sleep(5), problems(2), diet(1), financial arrangements(1) and relationships(1).

The most notable feature during Care Group One contacts was the emphasis on injection giving to the virtual exclusion of all other forms of nursing intervention. The absence of routine monitoring of drug side-effects and compliance with oral medicines suggests an emphasis on drug administration rather than drug efficacy or tolerance. The brevity of Care Group One contacts, which had a mean duration of 2.93 minutes, further illustrates the limited range of nursing interventions observed. Within these brief exchanges there would have be little time for any nursing activity other than the injection of a depot drug.

FIGURE 6.

NURSING INTERVENTIONS IN CARE GROUP ONE



N - 76 CONTACTS: 335 INTERVENTIONS - MEAN 4.41 PER CONTACT

Care Group Two

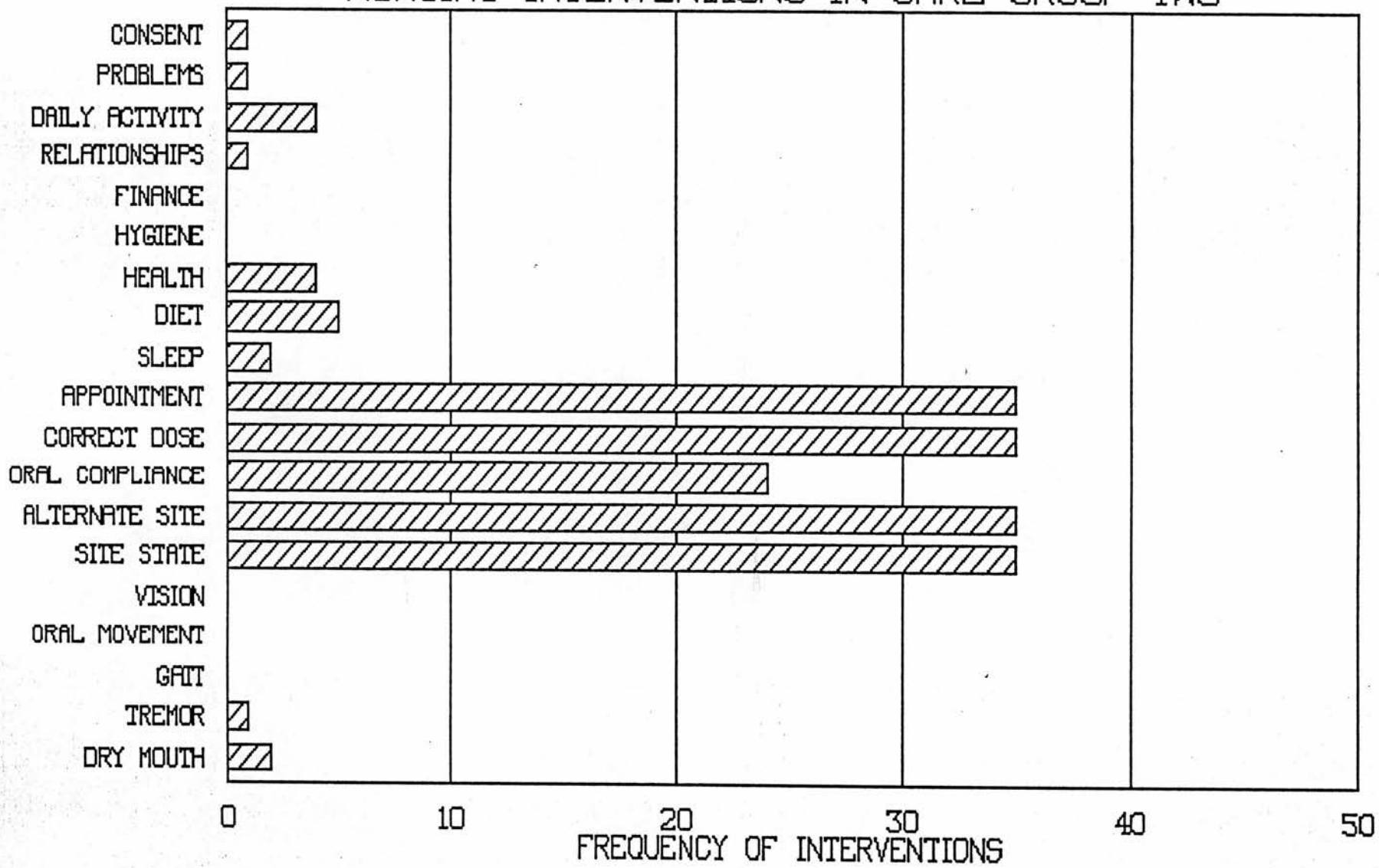
The 35 contacts in this care group all had a care score of six. The frequencies of the various nursing interventions observed are shown in Figure 7. The majority of interventions(75.68%) involved injection giving. Drug related interventions were more apparent compared with Care Group One but remained infrequent, accounting for less than 15 percent of the interventions observed(Table 3). Of the 27 drug related interventions 24 involved the monitoring of compliance with oral medicines so that only three interventions dealt with the monitoring of drug side-effects. Compliance with oral medicines was not monitored during eleven of the 35 contacts. Other care interventions were also infrequently observed and accounted for less that 10 percent of interventions, comprising of enquiries regarding; diet(5), general health(4), daily activity(4), sleep(2), relationships(1), problems(1) and consent to injection(1).

Care Group Three

The 48 contacts in Care Group Three all had care scores of seven, eight or nine. Figure 8 shows the composition of the 320 nursing interventions observed. As Table 3 shows the majority of these(60.00%) related to injection giving. However, because of the increased number of drug related and other care interventions observed, the injection category accounts for a lesser proportion of interventions during these contacts compared with those in Care Groups One and Two.

FIGURE 7.

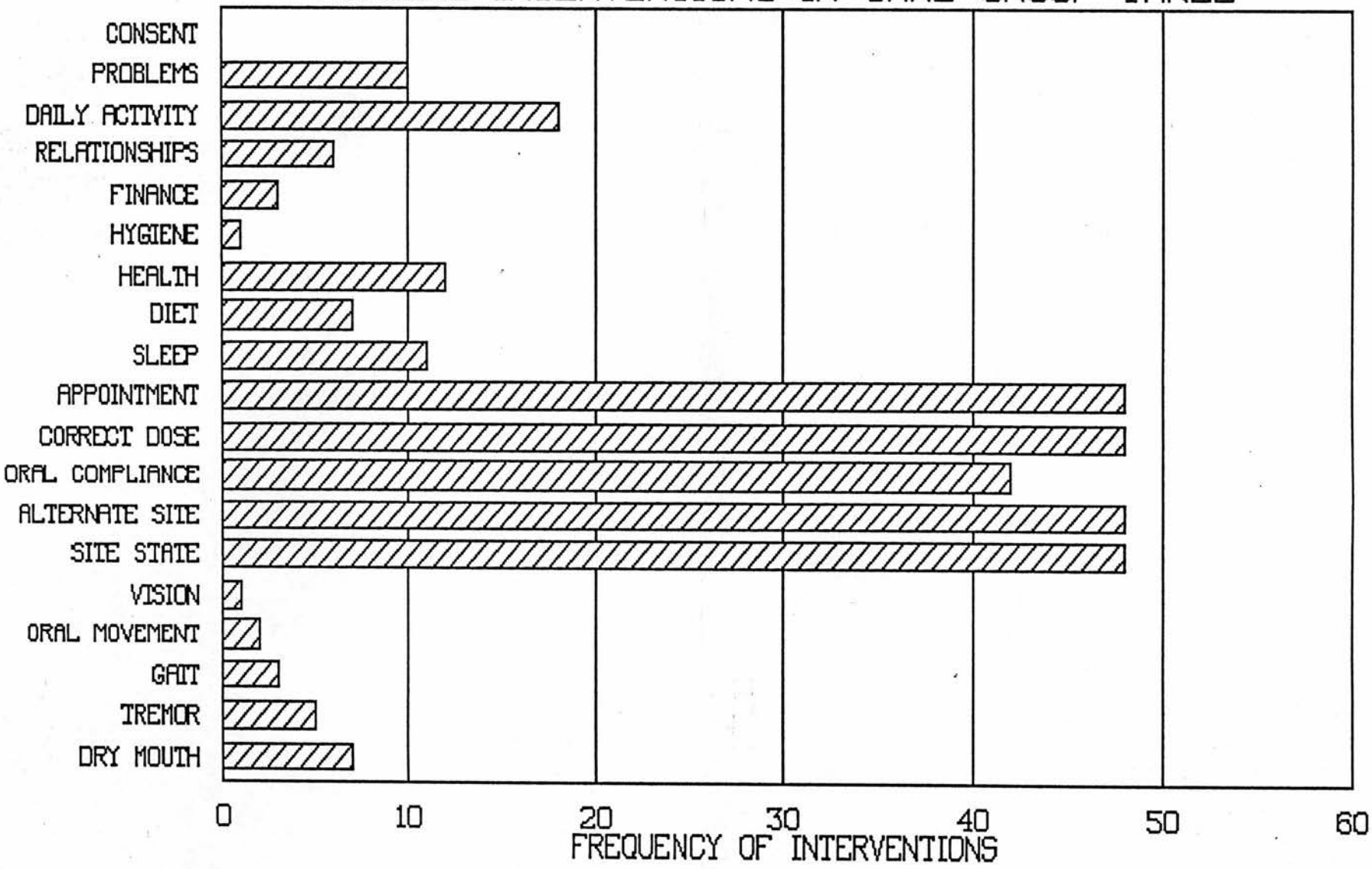
NURSING INTERVENTIONS IN CARE GROUP TWO



N = 35 CONTACTS; 185 INTERVENTIONS

FIGURE 8.

NURSING INTERVENTIONS IN CARE GROUP THREE



N = 48 CONTACTS: 320 INTERVENTIONS - MEAN 6.7 PER CONTACT

Sixty(18.75%) interventions were drug related, of which 42 involved monitoring compliance with prescribed oral medicines, and the remaining 18 drug side-effects. The monitoring of compliance with oral medicines was more apparent than during Care Group One and Two contacts, and nurses failed to monitor this during only six of the 48 contacts. Other care interventions were also more apparent and accounted for over 20 percent of the interventions observed, consisting of enquiries regarding: sleep(11), general health(12), relationships(6), daily activities(18), problems(10), diet(7), finance(3), and hygiene(1).

The nursing emphasis during these contacts remained injection orientated but to a substantially lesser extent than during Care Group One and Two contacts. The increased number of drug related interventions indicates that nurses paid more attention to drug issues other those involved with simply administering an injection. The more frequently observed other care interventions confirm that nurses also to carried out a more comprehensive assessment of their patients needs during these contacts. The mean duration of 5.31 minutes was considerably longer than in Care Groups One and Two, reflecting the increased number and more comprehensive range of interventions observed.

Care Group Four

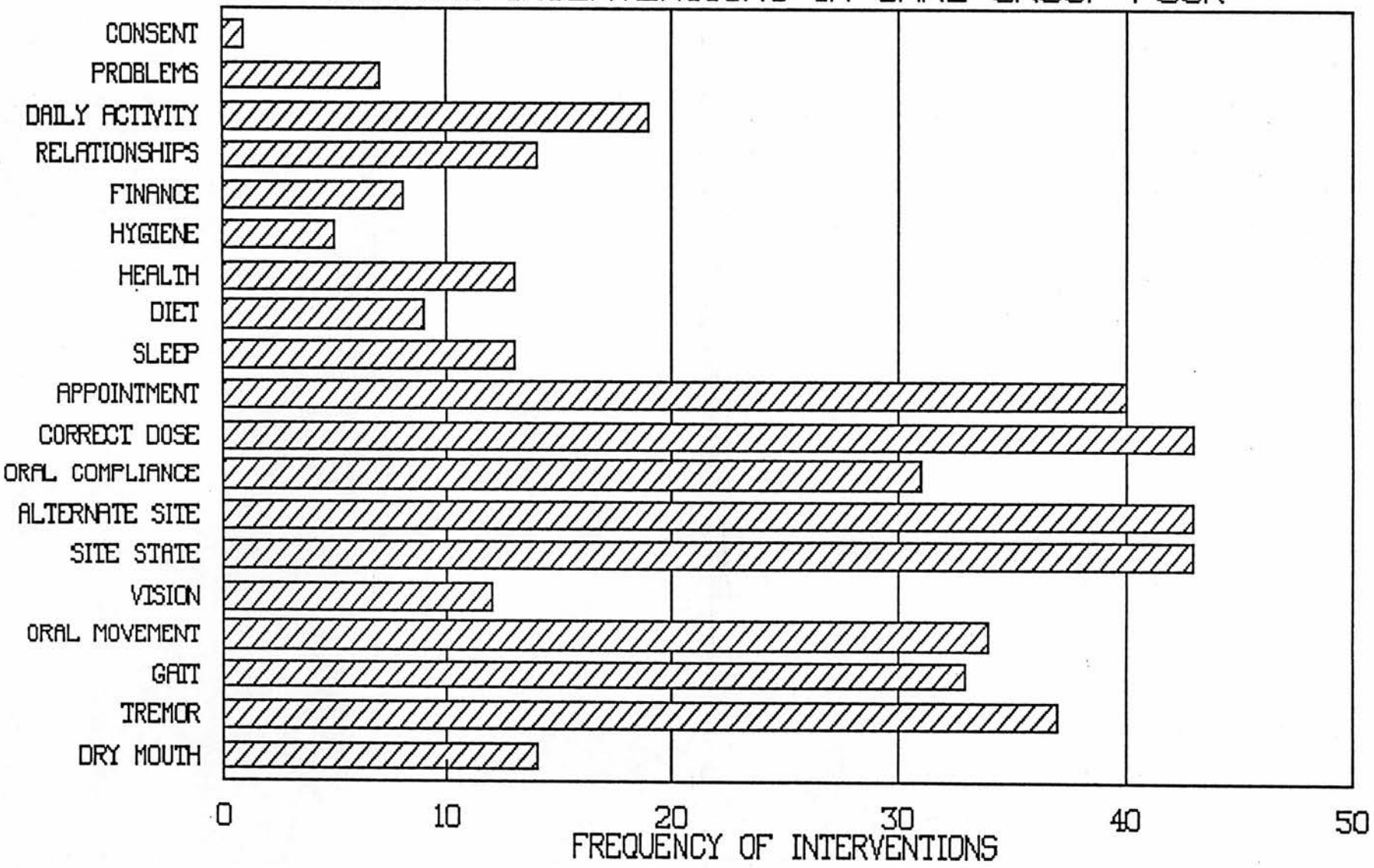
The 43 contacts in Care Group Four are those with the highest care scores of between 10 and 17. Figure 9 shows the frequency of interventions observed during these contacts. As Table 3 shows only

40.33 percent of interventions observed involved injection giving. This represents the lowest proportion of injection interventions in any of the four care groups. Conversely, drug related interventions were more numerous and accounted for 161(38.42%) of the 419 interventions observed, of which 130 involved the monitoring of drug side-effects. Over 85 percent of all drug side-effects interventions were observed during Care Group Four contacts. A score for monitoring compliance with oral medicines was awarded in 31 of the 43 contacts. Other care interventions accounted for the remaining 89(21.24%) interventions and comprised of enquiries regarding; daily activities(19), relationships(14), general health(13), sleep(13), diet(9), problems(7), finance(8), hygiene(5) and consent to injection(1).

The emphasis during these highest care score contacts remained firmly drug orientated. However, these contacts were particularly characterised by the frequent monitoring of drug side-effects. The mean contact duration of 8.74 minutes was the the longest of any care group, and is over three times the mean duration of Care Group One contacts. This also relates to the focus on drug side-effects monitoring since these interventions usually involved a series of physical examinations, which were more time consuming than verbal enquiries. Compared with Care Group One these contacts produced, on average, over twice the number of observed nursing interventions per contact(Table 3).

FIGURE 9.

NURSING INTERVENTIONS IN CARE GROUP FOUR



N = 43 CONTACTS; 419 INTERVENTIONS – MEAN 9.74 PER PATIENT

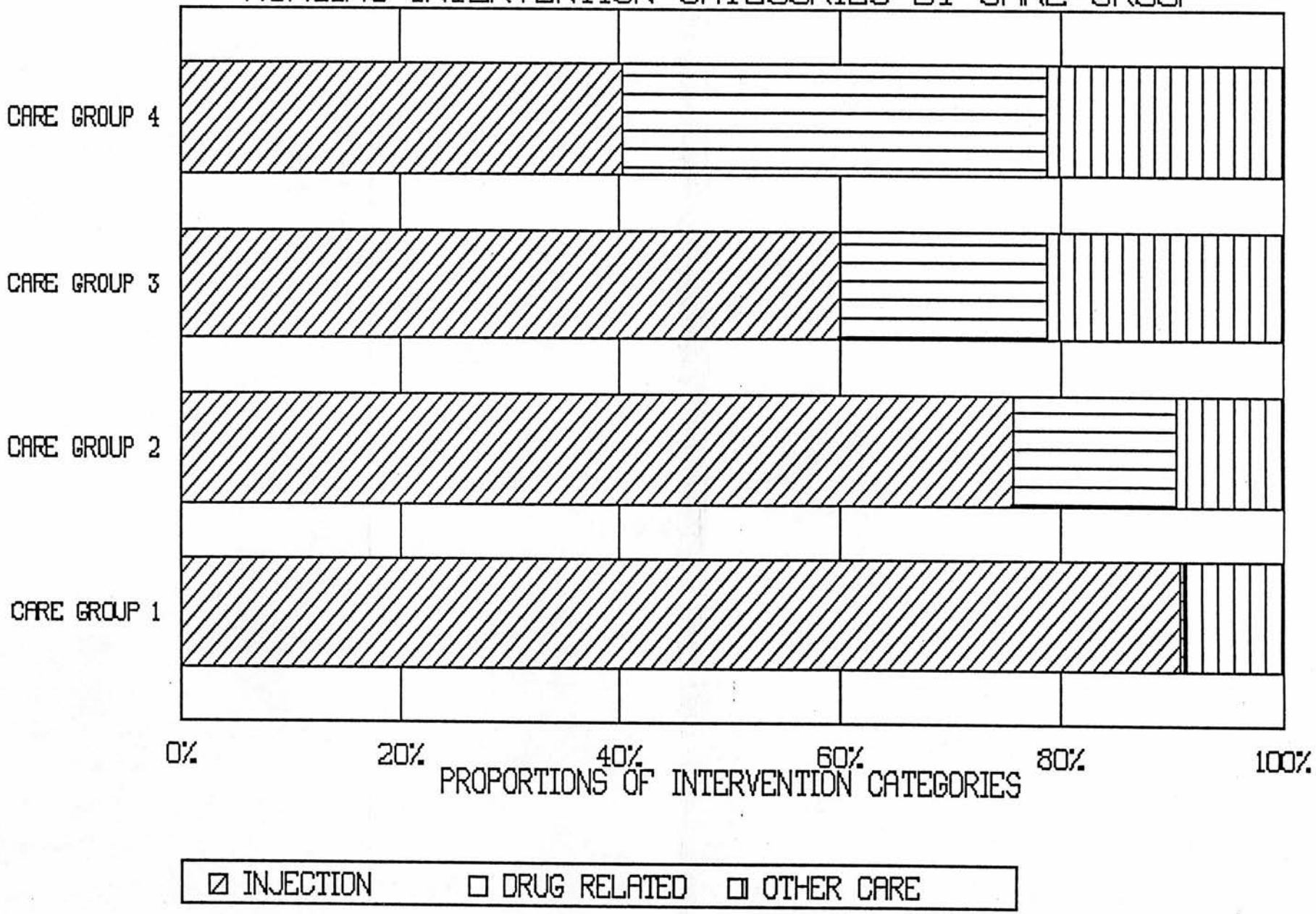
Standards of Nursing Care between Care Groups.

Since contacts were allocated to care groups on the basis of the care score it it not surprising to finds that care scores between the care groups were significantly different(KW = 188.92, p = <0.01). When the care scores of contacts are expressed in terms of scores from the three categories of nursing interventions significant differences were found in the care scores arising from both drug related interventions (KW = 169.09 p = <0.001) and from other care interventions (KW = 69.57 p = <0.001). The duration of contacts were also statistically significant between care groups (KW = 78.92 p = <0.001), confirming the earlier finding that longer contact durations were associated with higher care scores.

Figure 10 displays the proportions of the three categories of interventions in each care group. Here the column sizes are identical for each care group regardless of the number of interventions involved. The most obvious feature is the gradual reduction in the proportion of injection interventions as care scores increase as a consequence of increasing numbers of drug related and other care interventions. It is the increase in drug related interventions, and in particular drug side-effects monitoring, which accounts for much of the significant variation in care scores.

FIGURE 10.

NURSING INTERVENTION CATEGORIES BY CARE GROUP



The lowest scoring contacts, in Care Groups One and Two, were largely injection orientated and showed similar proportions of other care nursing interventions, which for both care groups accounted for less than 10 percent of interventions observed. The only difference of note between care scores in Care Groups One and Two was the complete failure of nurses to monitor compliance with oral medicines during Care Group One contacts. There was also minimal evidence of the routine monitoring of drug side-effects during Care Group One and Two contacts. This similarity is further illustrated by the finding that the durations of Care Group One and Two contacts were not significantly different.

Care Group Three contacts showed marked differences compared those in Care Groups One and Two. Whilst drug issues remained dominant the emphasis was less exclusively that of injection giving since there was more evidence of routine monitoring of compliance with oral medicines and, to a lesser extent, drug side-effects. Care scores were significantly different compared with Care Group Two ($U=538$ $p = <0.001$), with the significantly higher other care scores ($U = 406$ $p = <0.001$) confirm the more comprehensive range of interventions observed. As a result of the increased number of interventions Care Group Three contacts were significantly longer ($U = 460$ $p = <0.001$) than those in Care Group Two.

The emphasis on drug related interventions was most noticeable during the Care Group Four contacts. The more frequent monitoring of drug side-effects resulted in significantly higher drug related scores compared with Care Group Three contacts ($U = 108$ $p = <0.001$).

There was also a significant difference in other care interventions ($U = 774$, $p = <0.05$) but here the higher scores were found in Care Group Three. The duration of contacts was also significantly longer compared with Care Group Three contacts($U = 482$, $p = <0.001$), mainly because of the examinations used to monitor drug side-effects.
The findings regarding care groups reveal important and significant variations in the standards of nursing care observed. Further explorations of these data were undertaken to explore associations and differences in nursing care between other groups in this sample.

Standards of Nursing Care and Managerial Sectors

As described earlier the main study area consisted of four geographically defined managerial sectors. Table 4 shows findings from each sector.

Table 4: Interventions, Mean Care and Mean Duration in Sectors

	Sector One	Sector Two	Sector Three	Sector Four
Contacts	37	31	57	77
Mean Interventions per Contact	5.81	5.35	4.58	8.01
Injection Interventions(%)	68.84	74.70	87.36	49.43
Drug Related Interventions(%)	11.16	9.04	6.51	31.28
Other Care Interventions(%)	20.00	16.27	6.13	19.29
Mean Care Score	6.35	5.74	4.86	10.05
Mean Contact Duration(Minutes)	5.14	3.39	2.35	7.05

n = 202

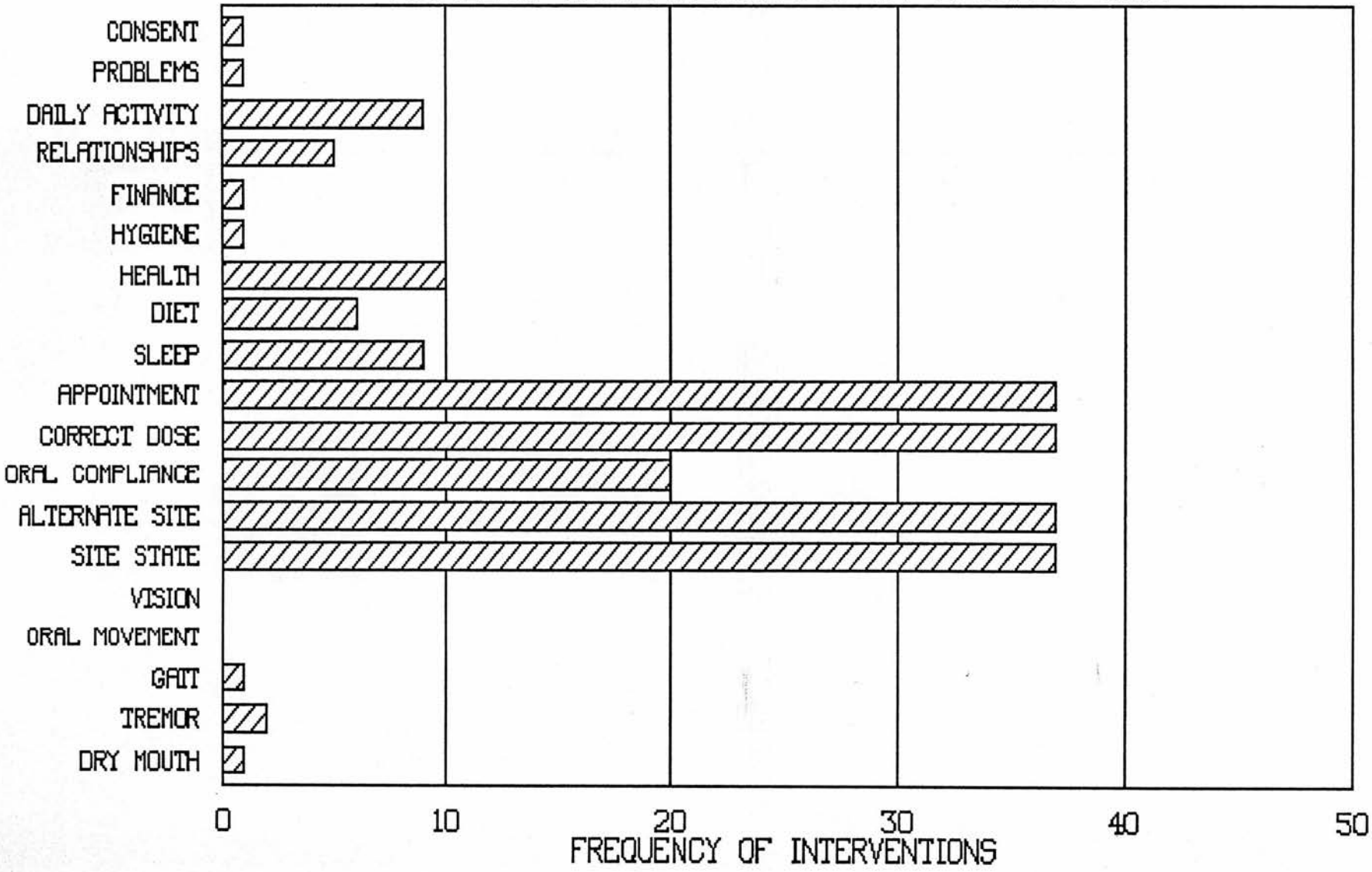
Managerial Sector One

Figure 11 shows the composition of the 215 nursing interventions observed during the 37 contacts in Sector One. Of these 18 were observed in Setting One and the remaining 19 in Setting 4, both of which were CPN offices. In terms of care groups, 12(32.43%) contacts fall into Care Group One, 10(27.03%) to Care Group Two, 13(35.14%) to Care Group Three and two(5.41%) to Care Group Four.

Over two thirds(68.84%) of the interventions observed in Sector One involved the administration of injections(Table 4). A further 20 percent were the 43 other care interventions observed comprising of enquiries regarding; daily activity(9), relationships(5), general health(10), diet(6) and sleep(9), problems(1), financial arrangements(1) personal hygiene (1). One of the two contacts where the nurse expressly sought the consent of the patient before administering the injection occurred in Sector One. The remaining 24(11.16%) interventions were drug related, of which 20 involved the monitoring of compliance with oral medicines and four the monitoring of drug side-effects. There was a failure to monitor compliance with oral drugs during 17 of the 37 contacts.

Significant differences in the standard of nursing care observed were found between the the two settings in Sector One. The care scores for Setting Four contacts were significantly higher than for Setting One contacts ($u = 93.5$ $p = <0.02$). No significant differences between these two settings in terms of the scores

FIGURE 11.
NURSING INTERVENTIONS IN SECTOR ONE



N = 37 CONTACTS: 215 INTERVENTIONS - MEAN 5.81 PER CONTACT

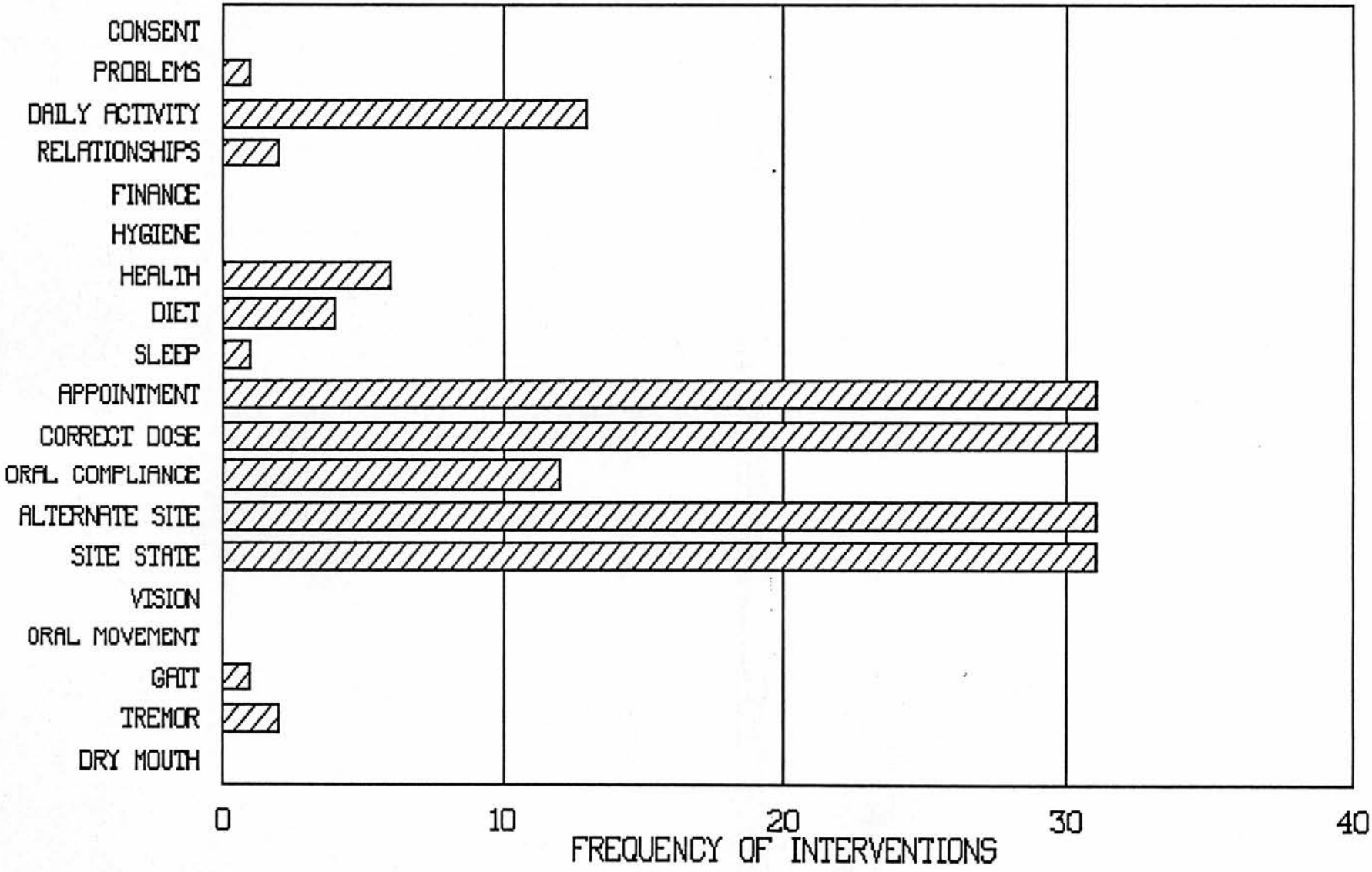
arising from the injection or drug related categories was found but there was significant difference in other care scores(U = 76.5 p = <0.01), with Setting Four producing the higher scores. This is reflected in the finding that 34(79.07%) of the 43 other care interventions observed in this sector occurred in Setting Four. The duration of Setting Four contacts were also significantly longer than for Setting One contacts (u = 50.5 p = <0.001), with means of 6.95 minutes and 3.22 minutes respectively, illustrating the greater number of interventions observed there.

For both settings in Sector One the emphasis during contacts was primarily that of administering depot drug injections. The monitoring of drug side-effects was virtually ignored while the nurses in both settings failed to monitor compliance with oral medicines during a similar proportion of contacts. The significantly higher care scores and longer contact durations in Setting Four were mainly the result of the greater number of other care interventions being observed.

Managerial Sector Two

As described earlier both the settings in Sector Two were the only two hospital clinics studied. These were also the only settings staffed by nurses who were not primarily community based and were located mainly in major hospital sites. Figure 12 shows that a total of 166 nursing interventions were observed during the 31 contacts. Fifteen of these were observed in Setting Two and the remainder in Setting Three.

FIGURE 12.
NURSING INTERVENTIONS IN SECTOR TWO



N = 31 CONTACTS: 166 INTERVENTIONS - MEAN 5.35 PER CONTACT

Fifteen(48.39%) of the 31 contacts were allocated to Care Group One, 6(19.35%) to Care Group Two and 10(32.26%) to Care Group Three. None of the Sector Two contacts attained care scores sufficient to allocate them to Care Group Four.

Most nursing interventions observed(74.70%) were those involving the administration of an injection. Other care interventions were infrequent and accounted for 27(16.27%) of interventions, and comprised of enquires regarding; daily activity(13), with general health(6), diet(4), relationships(2), problems(1) and sleep(1). Drug related interventions were more infrequent still, accounting for less that 10 percent of interventions. Twelve of the 15 drug related interventions observed involved the monitoring of compliance with oral medicines, which nurses failed to monitor during 19 of the 31 contacts. There was, therefore, little evidence of any routine monitoring of drug side-effects in this sector, since only three such interventions were observed.

There was no significant difference in care scores between the two hospital clinic settings. These contacts form the only group where a significant correlation between contact duration and care scores was not found. However contact time was significantly different between these two settings($U = 71.50$, $p = <0.045$), although the difference was marginal as the level of significance indicates. Since standards of nursing care were not significantly different between the two settings it is suggested that this finding relates more to variations in the working and administrative practices of these two settings, as nurses coped with the demands of larger caseloads and

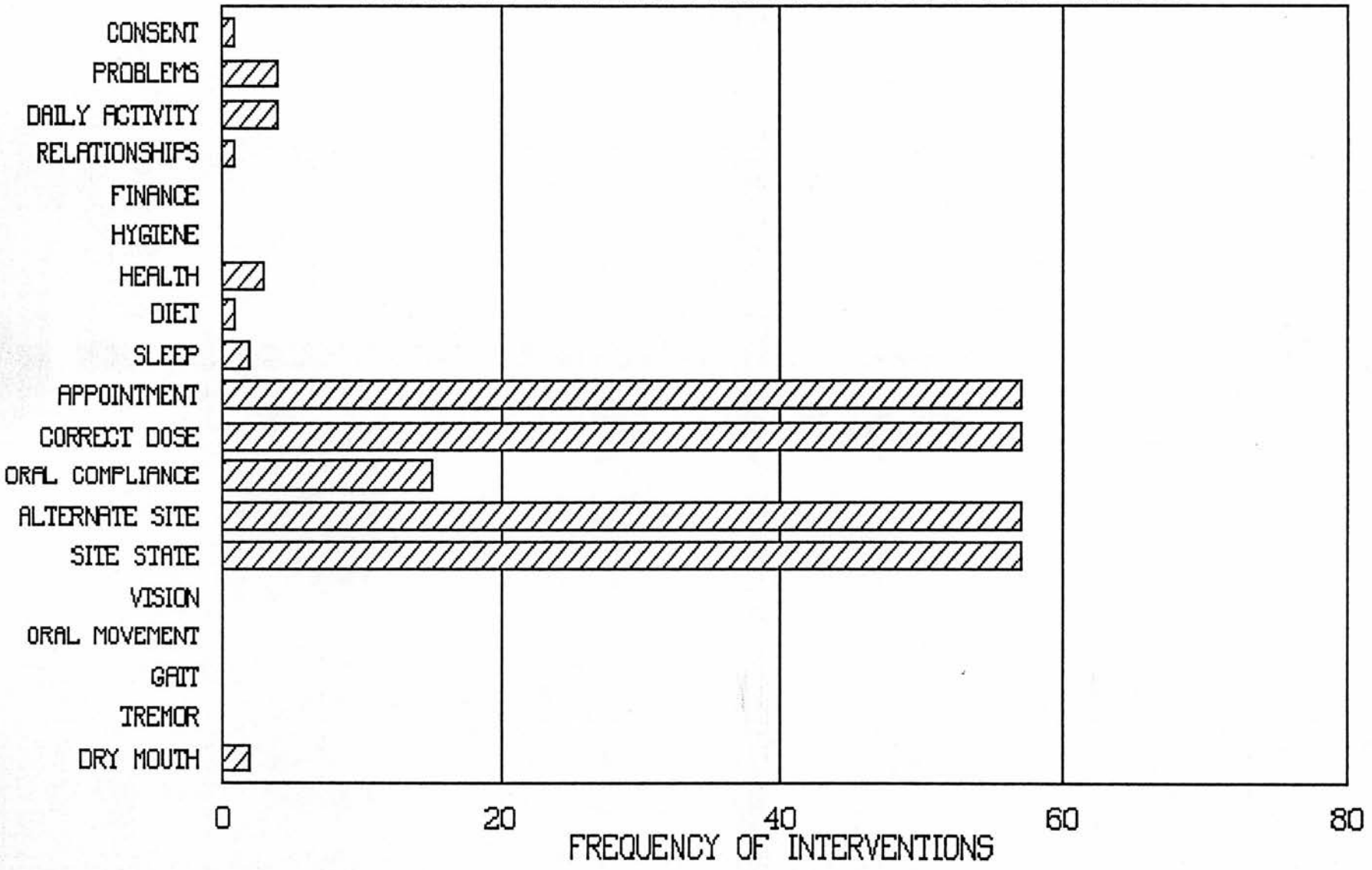
the concurrent activities of Hospital Consultants. For both settings in Sector Two the emphasis during contacts was primarily that of administering depot drug injections.

The monitoring of drug side-effects was virtually ignored during these contacts and both nurses regularly failed to monitor oral drug compliance. It may have been that they expected that this monitoring was the responsibility of medical staff, since they regularly saw many of these these patients before they received their injection. The field notes record that during several Sector Two contacts medical staff, having seen the patient prior to their attending the nurse for injection, amended their prescription in the presence of the researcher.

Managerial Sector Three

In this sector a total of 261 nursing interventions were observed during 57 contacts (Figure 13). Of these 18 were observed in Setting Five(CPN office), 22 in Setting Six(health centre), 10 in Setting Seven(health centre), and seven in Setting Eight(CPN office). Forty(70.18%) of the 57 contacts fell into Care Group One, 12(21.05%) into Care Group Two, and the remaining five(8.77%) to Care Group Three. None of the Sector Three contacts attained care scores sufficiently high to allow contacts to be allocated to Care Group Four.

FIGURE 13.
NURSING INTERVENTIONS IN SECTOR THREE



N = 57 CONTACTS: 261 INTERVENTIONS - MEAN 4.58 PER CONTACT

Of the interventions observed 228(87.36%) involved administering an injection, a further 17(6.51%) were drug related, of which 15 involved the monitoring of oral drug compliance, and only two relate to drug side-effects monitoring. Nurses failed to monitor compliance with oral medicines during 42 of the 57 contacts. Sixteen(6.13%) other care interventions were also observed and comprised of enquiries regarding; daily activity(4), problems(4), general health(3), sleep(2), relationships(1) and diet(1). One of the two contacts where the nurse expressly sought the consent of the patient before administering the injection occurred in Sector Three.

Because of the general absence of interventions other than those related to the administration of injections no significant differences in either care scores or the duration of contacts was found between any of the Sector Three settings. In all four settings the emphasis was primarily that of the administration of depot drug injections, the practicalities of which accounted for close to 90 percent of all the nursing interventions observed in this sector(Table 4). There was little evidence of the monitoring of either drug side-effects or compliance with oral medicines, or that these nurses addressed other care issues with any regularity.

This is supported by the finding that 40(70.18%) of the Sector Three contacts resulted in care scores appropriate to Care Group One, which contains the lowest care score contacts. This sector also accounted for 30(66.67%) of the 45 contacts which only attained the minimum care score of four. It was the emphasis on injection giving, to the virtual exclusion of all other nursing interventions, which particularly characterised the contacts observed in Sector Three.

Managerial Sector Four

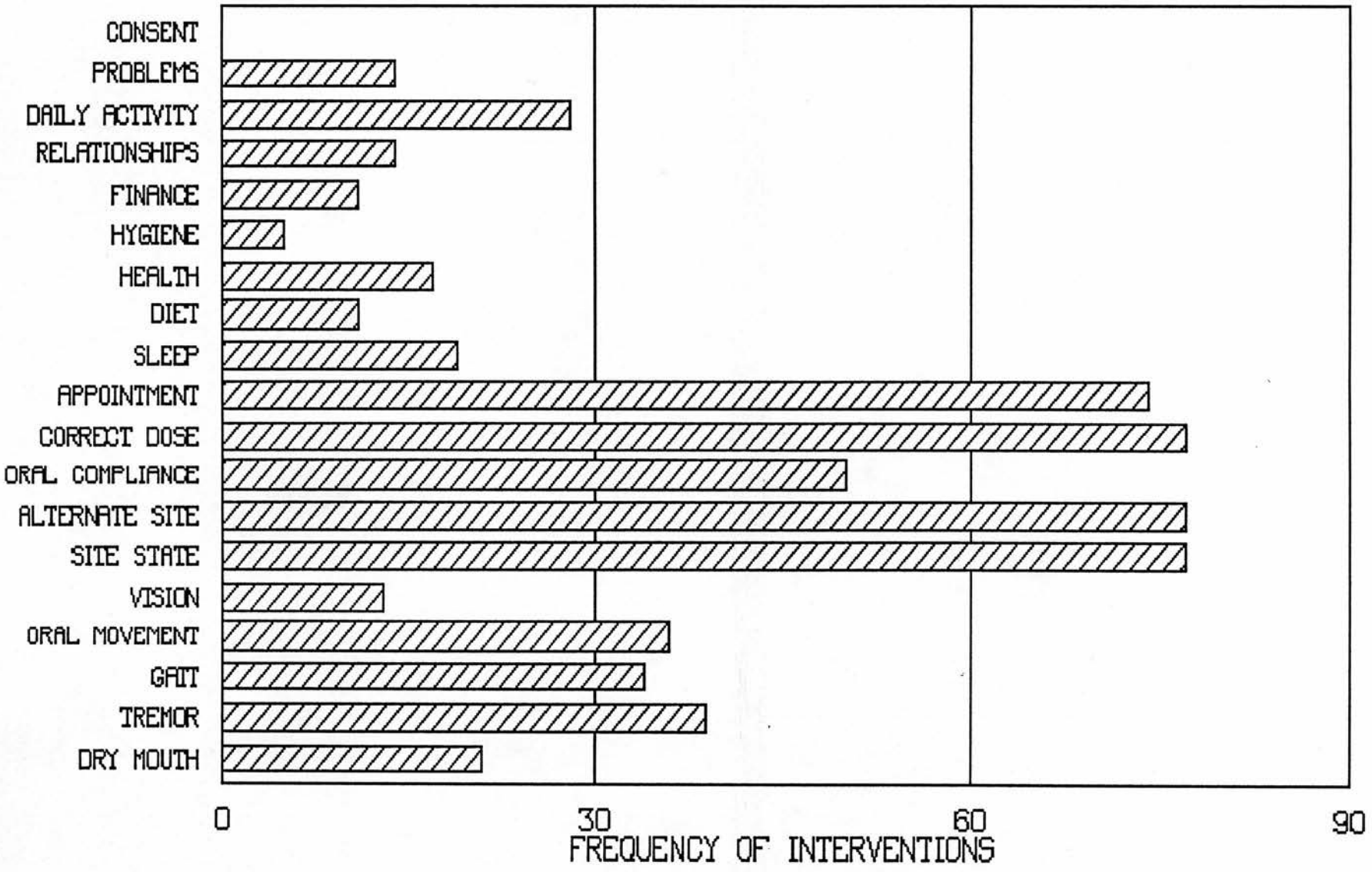
Figure 14 shows that a total of 617 nursing interventions were observed during the 77 contacts in Sector Four. Eleven contacts were observed in Setting Nine(health centre), 10 in Setting Ten(CPN office), five in Setting Eleven(health centre), three in Setting Twelve(CPN office), 13 in Setting Thirteen(health centre), 22 in Setting Fourteen(health centre), seven in Setting Fifteen(health centre), and six contacts were observed in Setting Sixteen(health centre).

Of the 617 nursing interventions observed in this sector less than half(49.43%) involved the administration of injections. Consequently, drug related and other care interventions were more apparent, accounting for 31.28 percent and 19.29 percent of interventions respectively(Table 4). The majority of Sector Four contacts, 41(53.25%) of 77, fell into to Care Group Four, which comprised of the highest care score contacts. A further 20(25.97%) contacts were allocated to Care Group Three, seven(9.09%) to Care Group Two, and the remaining nine(11.69%) to Care Group One.

A significant difference in care scores between these settings was found($KW = 25.64$ $p = <0.001$), which arises from a significant difference in drug related care scores($KW = 25.72$ $p = <0.001$). Care scores arising from both the injection and other care categories, or the duration of contacts, were not significantly different between Sector Four settings.

FIGURE 14.

NUSRING INTERVENTIONS IN SECTOR FOUR



N = 77 CONTACTS: 617 INTERVENTIONS - MEAN 8.01 PER CONTACT

As Figure 14 clearly shows the monitoring of drug side-effects was most frequently observed in this sector. This was largely the result of the GEPAS information system, which required that nurses monitor drug side-effects and record their findings. Nurses in Sector Four also more often monitored compliance with oral medicines, although they still failed to monitor this during 27 of the 77 contacts.

In the three settings in this sector with significantly lower drug-related care scores the caseloads may have contained fewer patients for whom the GEPAS records were kept, since GEPAS only applied to patients referred by Hospital Consultants and was not used for those referred by GPs. Consequently, during some of the contacts observed in Sector Four settings nurses may not have been required to monitor drug-side effects in order to comply with GEPAS, resulting in lower drug related care scores. This also suggests that these nurses tended not to routinely monitor drug side-effects unless prompted to do so by the demands of the GEPAS system

For settings in Sector Four the emphasis during contacts was again drug orientated, since less than 20 percent of interventions were of the other care variety(Table 4). However, an increased focus on drug related interventions, and particularly the monitoring of drug side-effects, was observed, and is clearly illustrated in Table 4, which also shows that this sector produced, on average, the greatest number of observed interventions per contact. It was the reduced emphasis on just giving injections and the focus on drug side-effects monitoring which particularly differentiates Sector

Four contacts. Undoubtedly an important factor here were the demands of the GEPAS system which, although not applicable to all patients attending these settings, did require nurses to more regularly carry out specific interventions involving the monitoring of drug side-effects.

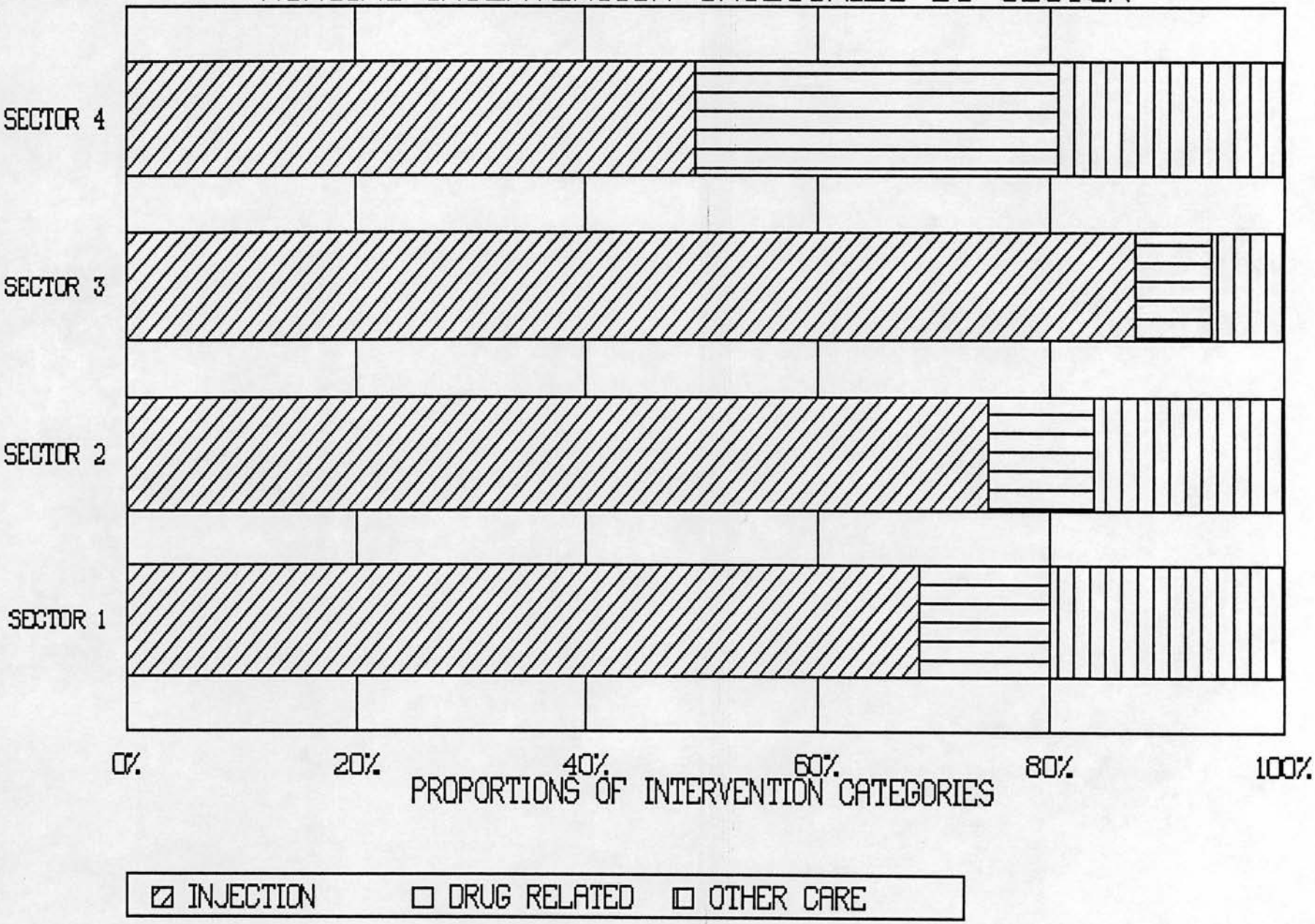
Standards of Nursing Care between Managerial Sectors

The previous findings described a marked variation in the number and type of nursing interventions observed in each of the four sectors. These are reflected in the significant differences in care scores(KW = 91.91 p=<0.001) and contact durations(KW = 86.85 p = <0.001) between sectors. Figure 15 shows the differences in the proportions of intervention categories between sectors. Significant differences were also found in the care scores arising form other care interventions (KW = 44.75 p = <0.001) and, in particular, from drug related interventions (KW = 77.16 p = <0.001). The allocation of contacts to the four care groups was also significantly different(Chi-Squared = 105.16, p = <0.001), where contacts in two of the four sectors did not attain care scores appropriate to Care Group Four. In addition 41(95.35%) of the 43 Care Group Four contacts were observed in Sector Four.

The finding of a significant difference in care scores arising from other care interventions was largely a consequence of the virtual absence of these interventions in Sector Three. As Table 4 shows in Sectors One Three and Four other care interventions accounted for

FIGURE 15.

NURSING INTERVENTION CATEGORIES BY SECTOR



between 16 and 20 percent of interventions compared with less that seven percent in Sector Three. Sector Three also had the lowest average number of interventions per contact, at just over the minimum care score of four(Table 4).

The significant difference in drug-related scores reflects the particular focus on these interventions in Sector Four, which accounted for close to one third of drug-related interventions observed compared with between six and 12 percent in the other sectors. This again reflects the GEPAS information system unique to Sector Four, which accounted for over 90 percent of all drug side-effects monitoring interventions observed.

Standards of Nursing Care and Grade of Nurse

As described in Chapter Five three grades of nurses were defined. Table 5 shows findings relating to each of these grades.

Table 5: Interventions, Mean Care and Mean Duration in CPN Grades

	CPN One	CPN Two	CPN Three
Contacts	60	111	31
Mean Interventions per Contact	6.32	6.43	5.35
Injection Interventions(%)	62.53	62.18	74.70
Drug Related Interventions(%)	20.05	22.13	9.04
Other Care Interventions(%)	17.41	15.69	16.27
Mean Care Score	7.58	7.49	5.74
Mean Contact Duration(Minutes)	4.93	5.14	3.39

n = 202

CPN One Nurses

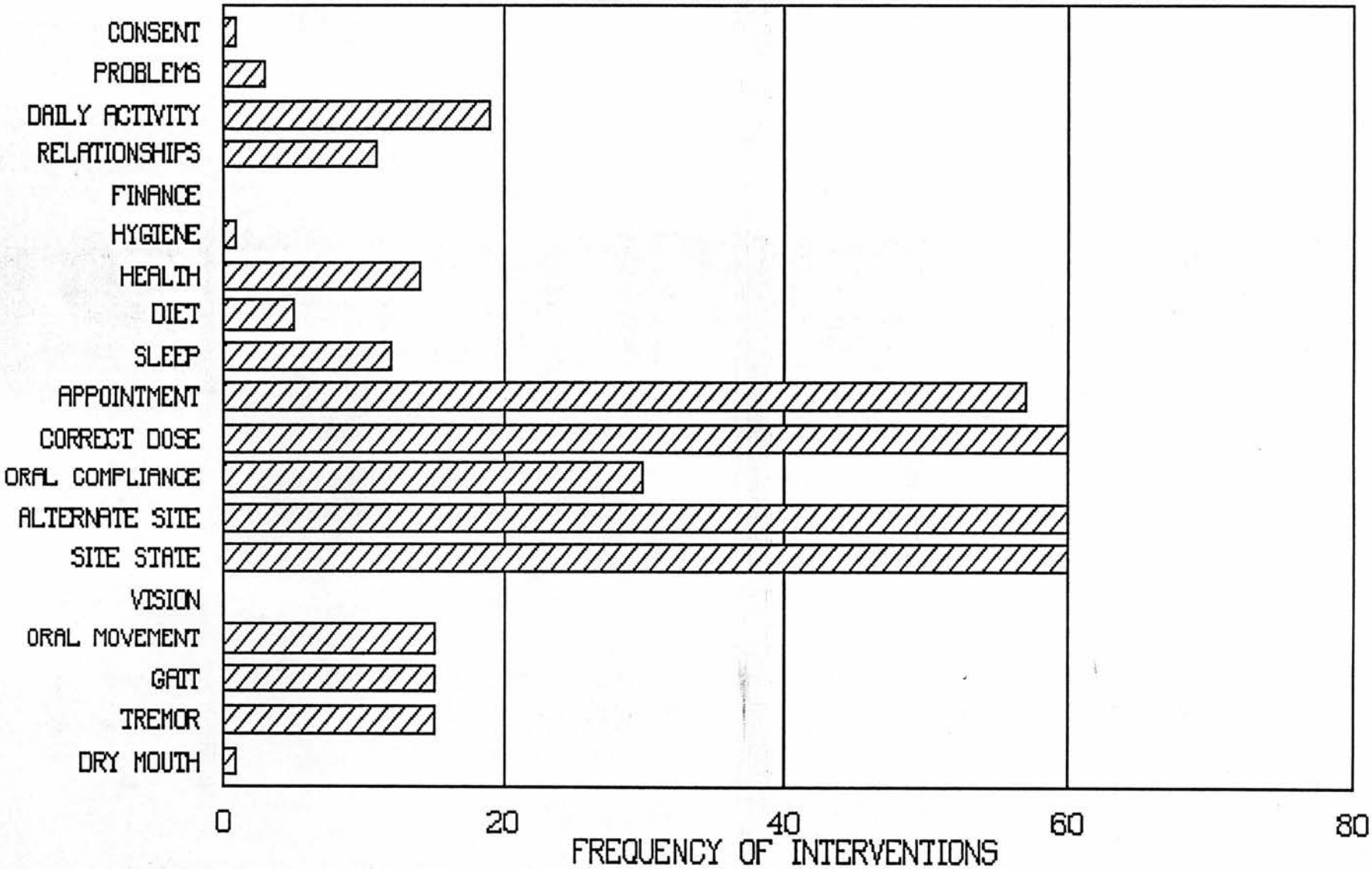
A total of 379 interventions were observed during the 60 contacts involving CPN One nurses(Figure 16), As Table 5 shows almost two thirds of these interventions(62.53%) involved the administration of an injection. A further 76(20.05%) were drug related, of which 46 involved the monitoring of drug side-effects, and other care interventions accounted for the remaining 66(17.41%). These comprised of; daily activities(19), general health(14), sleep(12), relationships(11), diet(5), problems(3), personal hygiene(1) and consent(1). Compliance with oral medicines was not monitored during 30(50.00%) of the 60 contacts. In terms of care groups 18(30.00%) of these contacts fell into the lowest scoring Care Group One, 12(20.00%) into Care Group Two, 14(23.33%) into Care Group Three and the remaining 16(26.67%) contacts into Care Group Four.

CPN Two Nurses

The 111 contacts involving CPN Two nurses produced a total of 714 interventions(Figure 17). Of these 444(62.18%) involved the administration of an injection. Drug related interventions accounted for a further 158(22.13%), with 103(65.19%) of these involving drug side-effects monitoring. Compliance with oral medicines was therefore not monitored during 56(50.45%) of the 111 contacts. The remaining 112(15.69%) interventions were of the other care category and comprised of enquiries regarding; daily activities(22), general health(5), sleep(18), relationships(16), finance(12), diet(13), problems(18), personal hygiene(5) and consent(1). Of these 60

FIGURE 16.

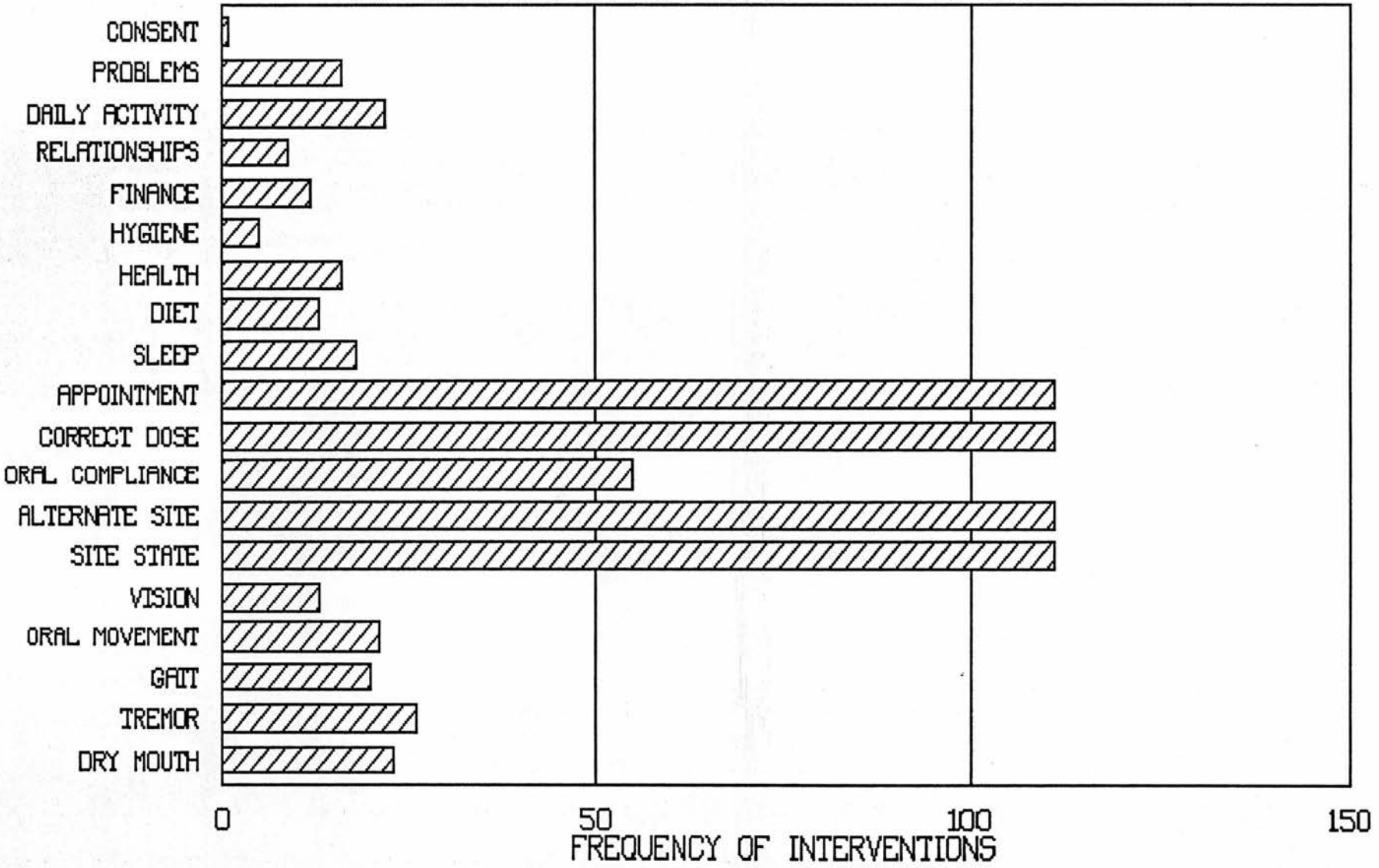
NURSING INTERVENTIONS BY CPN ONE NURSES



N = 60 CONTACTS: 379 INTERVENTIONS - MEAN 6.32 PER CONTACT

FIGURE 17.

NURSING INTERVENTIONS BY CPN TWO NURSES



N = 111 CONTACTS: 714 INTERVENTIONS - MEAN 6.43 PER CONTACT

contacts 43(38.74%) were allocated to Care Group One, 17(15.32%) to Care Group Two, 24(21.62%) to Care Group Three, and the remaining 27(24.32%) contacts to Care Group Four.

CPN Three Nurses

Because of the nature of the sample the CPN Three contacts are identical to those found in Sector Two in that they involve the same contacts. These have been detailed earlier(see Sector Two findings). The composition of these interventions is also shown in Figure 18.

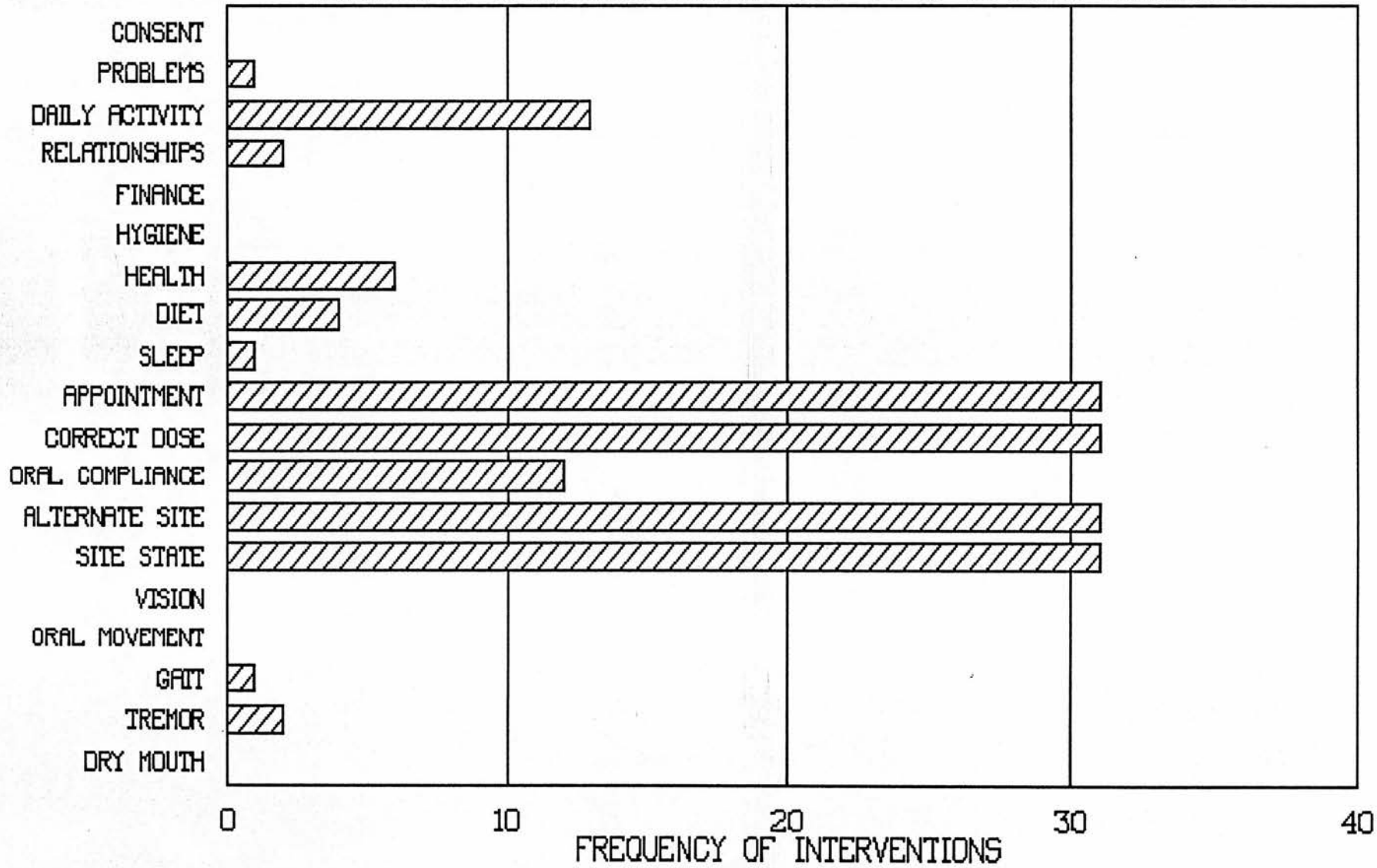
Standards of Nursing Care between Grades of Nurse

Between contacts involving the three CPN grades no significant differences in care scores or contact duration were observed. The care scores arising from the other care and injection intervention categories were not significantly different. However, a significant difference was found in care scores arising from drug related interventions ($KW = 7.18$ $p = <0.05$). This occurs as a consequence of the minimal number of drug related interventions observed in the two hospital clinics staffed by both the CPN Three nurses. As Figure 19 shows the CPN Three nurses were the least effective in terms of monitoring both drug side-effects and compliance with oral medicines.

If the hospital clinic nurses are excluded and a comparison is made between the two groups of CPN department based nurses (those who held post-basic qualification and those who did not) no significant

FIGURE 18.

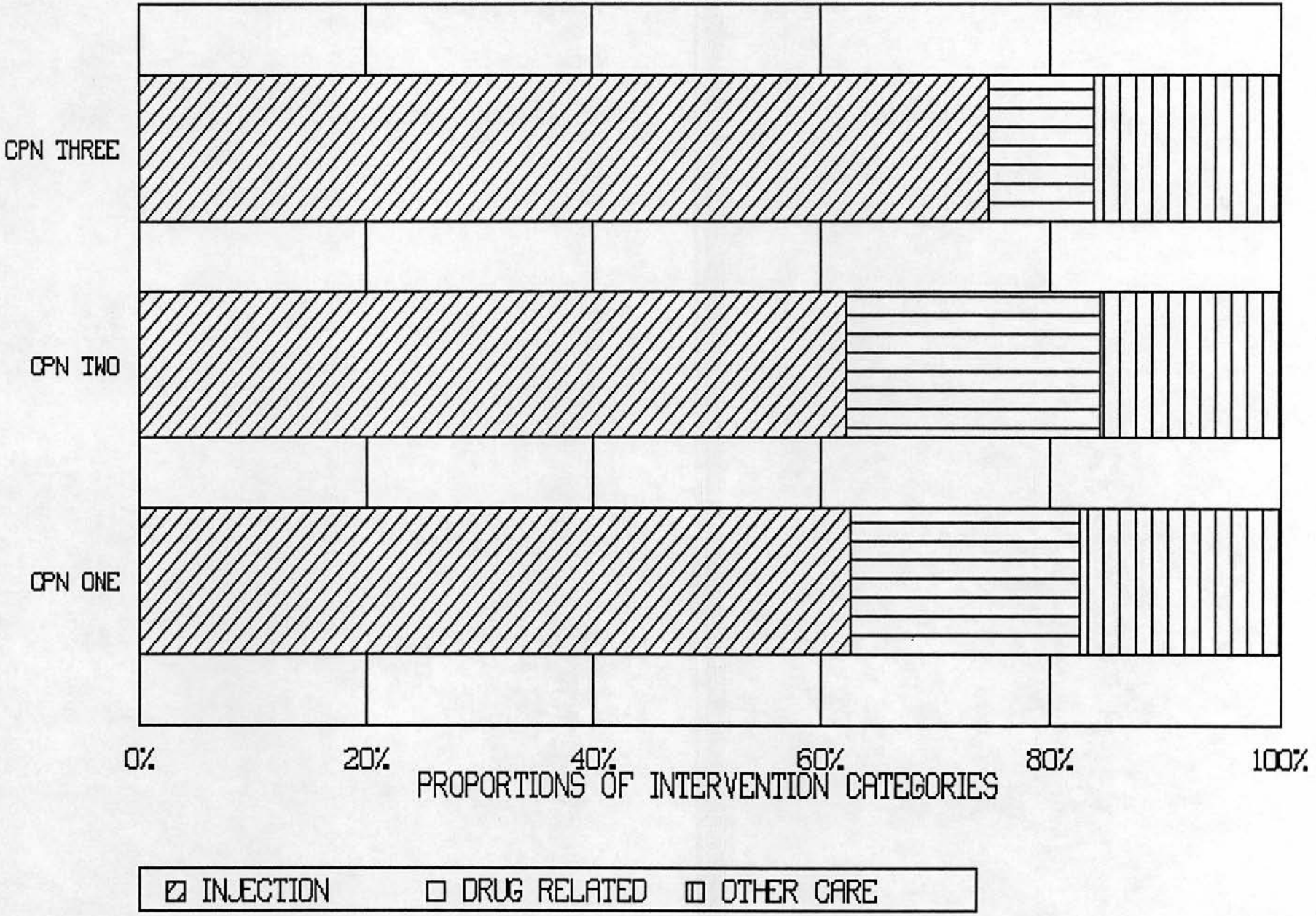
NURSING INTERVENTIONS BY CPN THREE NURSES



N = 31 CONTACTS: 166 INTERVENTIONS - MEAN 5.35 PER CONTACT

FIGURE 19.

NURSING INTERVENTION CATEGORIES BY CPN GRADE



differences in care scores were found. These two groups had similar proportions of injection, drug related and other care interventions and were not significantly different in terms of the allocation of contacts to care groups. There was therefore little evidence from the 171 observed contacts involved both CPN grades that those nurses holding post-basic qualification practised better standards of nursing care than those without such qualification.

Although a significant difference in care scores between the four sectors was found no significant difference between CPN One and CPN Two nurses was found in any of the three sectors containing both these grades of CPN. While CPN Two nurses did monitor drug side-effects more often than CPN One nurses the care scores arising from these interventions alone were not significantly different between the two groups. This is further illustrated by the mean care scores of CPN One and CPN Two nurses in each of the three sectors containing both grades; 6.21 and 6.89 respectively in Sector One, 4.70 and 4.89 respectively in Sector Three, and 10.89 and 9.75 respectively in Sector Four.

Apart from confirming the contrast between in nursing care provided in each sector, and the comparative excellence of Sector Four nurses, these findings also demonstrate the similarity in care scores achieved by CPN One and CPN Two nurses within each of these three sectors. These findings suggest that CPNs in each sector demonstrated a similar standard of nursing care during depot drug contacts irrespective of whether or not they held a post-basic qualification.

Standards of Nursing Care and Types of Setting

As described earlier, each of the settings studied was described as being either a hospital clinic, a CPN office, or a local health centre. Each of these types of setting tended to have particular characteristics. Hospital clinics were closely related to the working patterns of medical staff, while the CPN offices were located in facilities most often used by Health Visitors and District Nurses, and were the most spartan terms in furnishing and amenities. In comparison the settings located in health centres enjoyed better facilities and had significantly lower caseloads. Table 6 shows findings from each type of setting.

Table 6: Interventions, Mean Care and Mean Duration by Setting Type

	Hospital Clinics	CPN Offices	Health Centres
Contacts	31	75	96
Mean Interventions per Contact	5.35	5.64	6.29
Injection Interventions(%)	74.70	70.92	56.87
Drug Related Interventions(%)	9.04	13.24	26.57
Other Care Interventions(%)	16.27	15.84	16.57
Mean Care Score	5.74	6.24	8.52
Mean Contact Duration(Minutes)	3.39	4.69	5.36

n = 202

Hospital Clinics

As noted earlier, and because of the nature of the sample, the hospital clinic findings are identical to those described in

relation to in Sector Two, and CPN One nurses in that they involve the same contacts. These have been detailed earlier(see Sector Two findings) and are also shown in Figure 20.

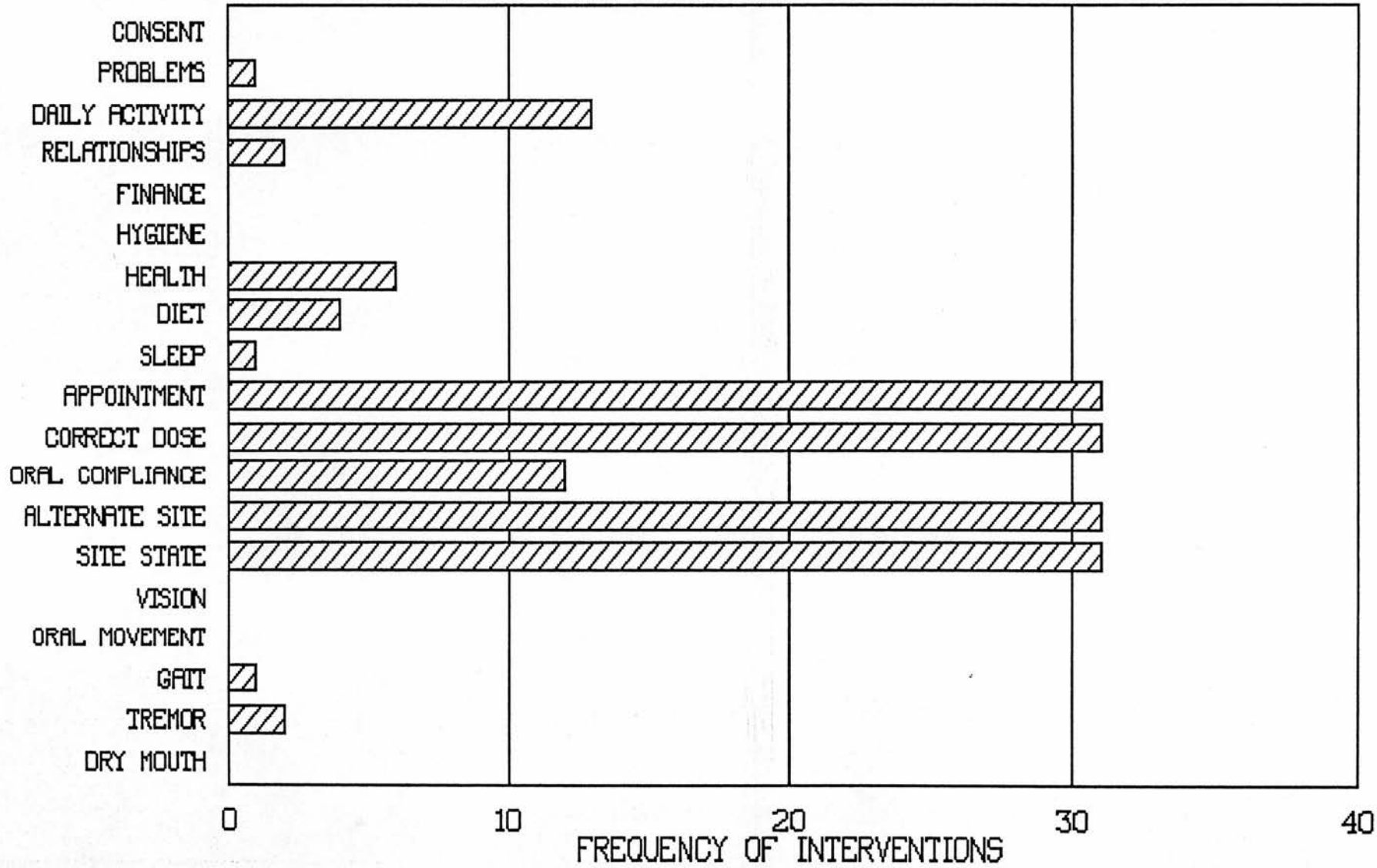
CPN Offices

The 75 contacts observed in CPN offices produced a total of 423 interventions. Of the six settings involved, two were located in Sector One (Settings One and Four), two were located in Sector Three (Settings Five and Eight), and the remaining two in Sector Four (Settings 10 and 12). Thirty-one(41.33%) of these contacts fell into Care Group One, 17(22.67%) into Care Group Two, 21(28.00%) into Care Group Three, and only the remaining 6(8.00%) contacts had care scores sufficient to attain Care Group Four.

Table 6, and Figure 21, show that 300(70.92%) of the interventions observed involved the administration of injections, and that drug related and other care interventions less frequently occurred. Nurses failed to monitor compliance with oral medicines during 40 of the 75 contacts and drug side-effects interventions were even less frequent, accounting for only 21(4.96%) interventions. The 67(15.84%) interventions in the other care category consisted of enquiries regarding; daily activities(15), general health(10), sleep(10), relationships(8), finance(4), diet(8), problems(9), personal hygiene(1) and consent(2). Both the interventions where nurses sought the patients consent to administer the depot injection occurred in CPN office settings.

FIGURE 20.

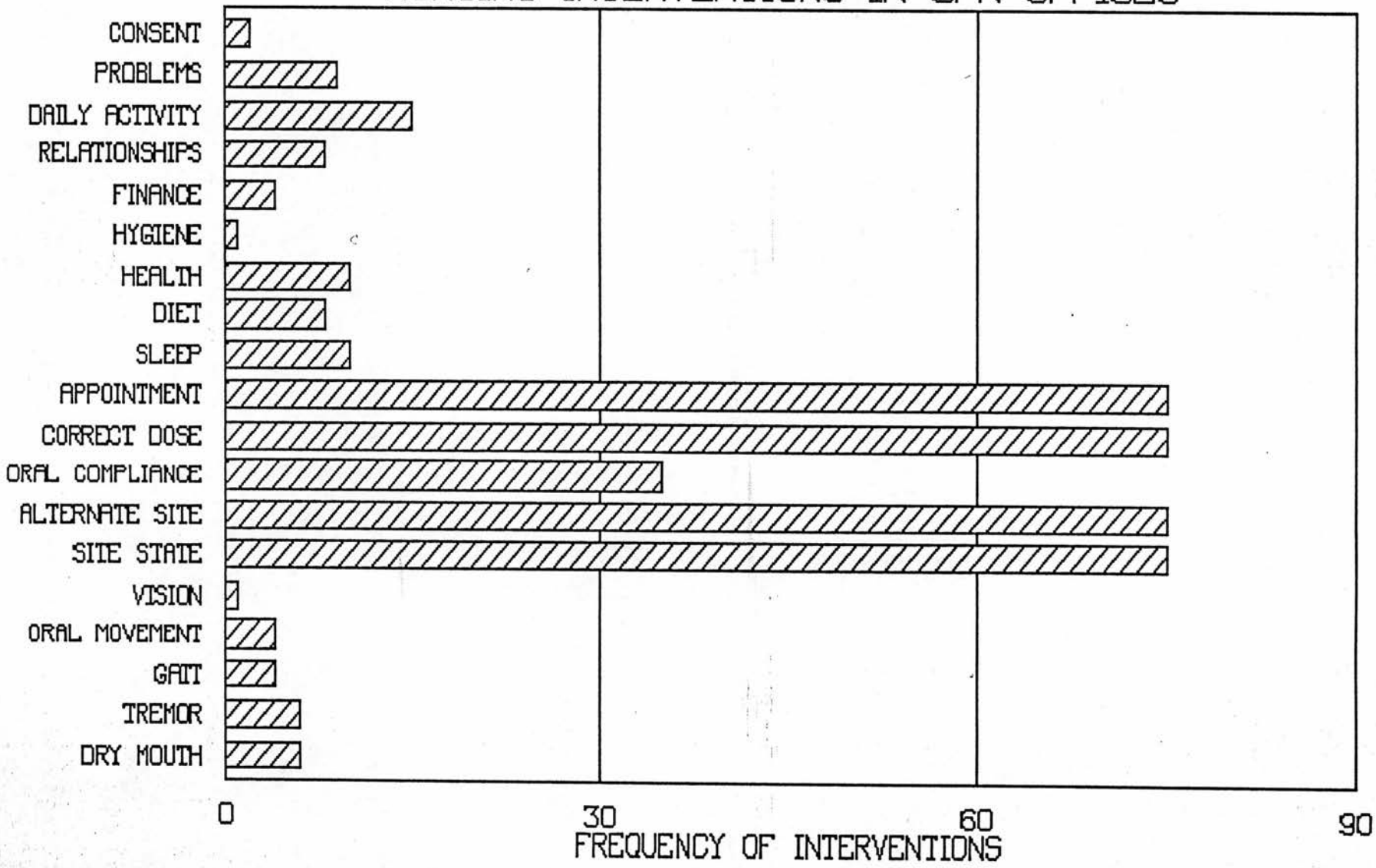
NURSING INTERVENTIONS IN HOSPITAL CLINICS



N = 31 CONTACTS: 166 INTERVENTIONS - MEAN 5.35 PER CONTACT

FIGURE 21.

NURSING INTERVENTIONS IN CPN OFFICES



N = 75 CONTACTS: 423 INTERVENTIONS - MEAN 5.64 PER CONTACT

Health Centres

The 96 contacts observed in health centres produced a total of 670 interventions, as shown in Figure 22. Of the eight settings involved, two were located in Sector Three (Settings Six and Seven), and the remaining six settings in Sector Four (Settings Nine, 11, 12, 13, 14, 15, and 16). In terms of care groups 30(31.25%) contacts were allocated to Care Group One, 12(12.50%) to Care Group Two, 17(17.71%) to Care Group Three, and 37(38.15%) to Care Group Four.

Of the 670 interventions observed 381(56.81%) involved the administration of an injection. Drug related interventions accounted for a further 178(26.57%), of which 50 related to oral compliance and the remaining 128 to the monitoring of drug side-effects. Compliance with oral medicines was not monitored during 46 of these contacts. Other care interventions accounted for the remaining 111(16.57%) interventions and comprised of; daily activities(26), general health(20), sleep(20), relationships(12), finance(8), diet(10), problems(10), and personal hygiene(5).

Standards of Nursing Care between Types of Setting

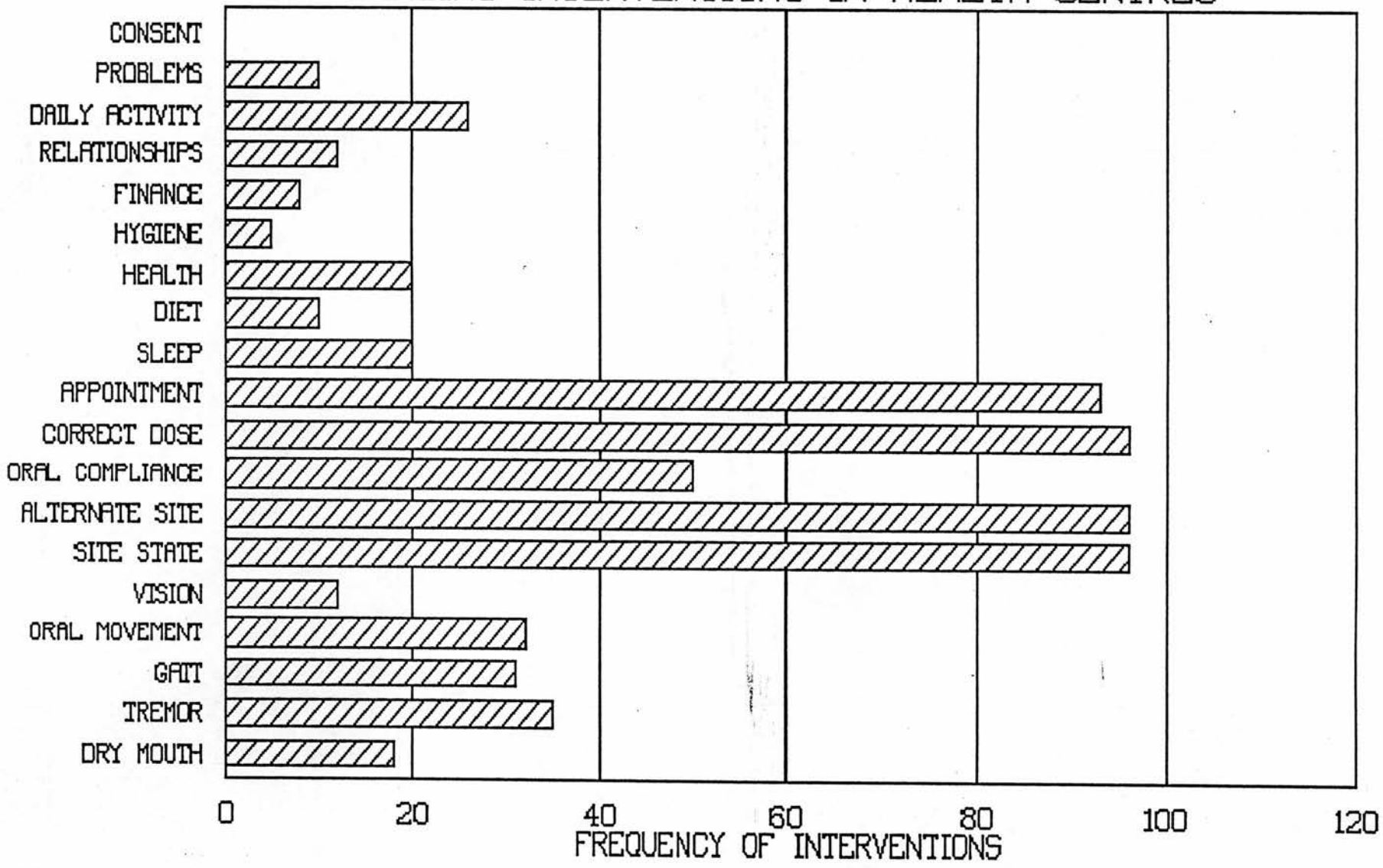
Between the three types of setting care scores were significantly different (KW = 15.47 p = <0.001). This is a consequence of a significant difference in drug related scores (KW = 20.32 p = <0.001), since no significant differences in terms of contact duration or care scores arising from injection and other care interventions were found. Of particular note is that 128(84.21%) of

the 152 drug side-effects interventions were observed in the health centre settings, most of which were located in Sector Four. Figure 23 shows the proportions of intervention types in hospital clinic, CPN office and health centre settings. The allocation of contacts to care groups was significantly different(Chi-Squared = 34.10, p = <0.001), with the eight health centre settings accounting for 37(86.05%) of the 43 highest scoring Care Group Four contacts.

These significant differences appear to relate primarily to the sector in which the various settings were located. In two of sectors the settings were all of the same type: CPN offices in Sector One and hospital clinics in Sector Two. Both the remaining sectors contained both CPN office and health centre settings and analysis reveals no significant differences in the standards of nursing care between the two types of depot drug setting in either sector.

This gives further support to the proposal suggestion made that nurses in each sector practised similar standards of care irrespective of either their grade or the type of setting in which they were observed. Health centre settings produced the significantly higher care scores, mainly as a consequence of the greater frequency of drug related interventions, and constituted all but six of the highest scoring Care Group Four contacts. This is a further illustration of the effects of the GEPAS system since six of the eight health centre settings were located in Sector Four.

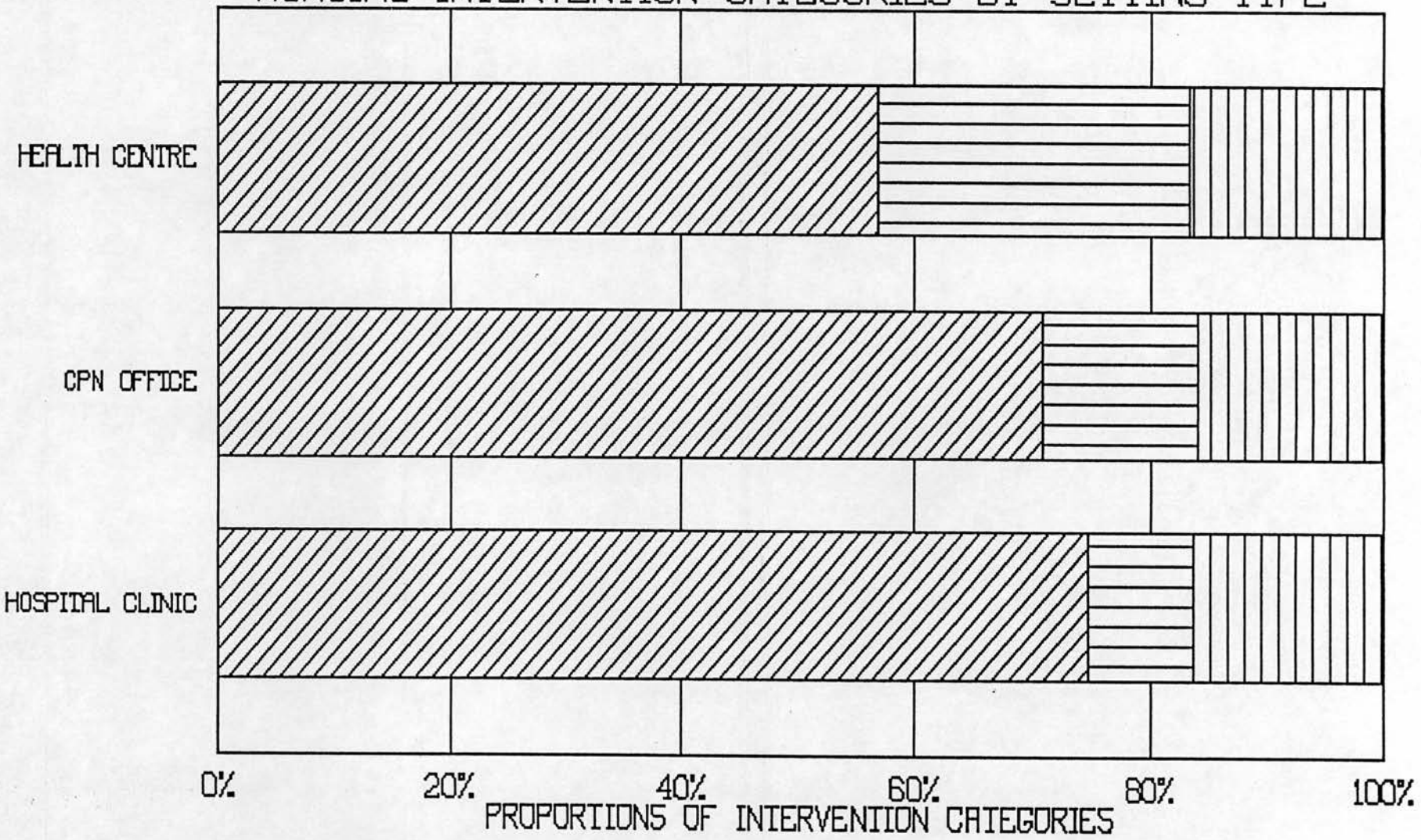
FIGURE 22.



N = 96 CONTACTS: 670 INTERVENTIONS - MEAN 6.98 PER CONTACT

FIGURE 23.

NURSING INTERVENTION CATEGORIES BY SETTING TYPE



HOSPITAL CLINICS; N = 166. CPN OFFICES; N = 423. HEALTH CENTRES; N = 670.

Standards of Nursing Care and Characteristics of Patients.

No significant differences were found with regard to the care scores or duration of contacts between the sexes. The only significant difference was in the frequency of daily activity interventions (Chi-Squared = 5.38 p = <0.05), where 40(74.07%) of the 54 enquiries were addressed to male patients.

Between patients who lived alone and those who lived with others no differences in care scores were found. However, the duration of contacts was significantly different (U = 3784.5 p = <0.05). Patients who lived alone tended to have briefer contacts, with a mean duration of 4.01 minutes compared with 5.29 minutes for those living with others. This significant difference, while not accompanied by differences in the standard of nursing care observed, may be a consequence of nurses simply have less to converse about with patients living alone, in that much of the social conversation documented in the field notes was about family issues.

Standards of Nursing Care and Caseload Size

The number of contacts observed in each setting was significantly correlated with the caseload size of settings. This finding occurs because the sampling method involved observing all contacts during each depot clinic session attended, and more contacts were scheduled during sessions in the higher caseload settings. No significant correlation was found between the personal caseload size of nurses and the number of observations made of each nurse. In addition no

significant correlations were found between caseload size and the mean care score and duration time of contacts observed of each nurse. These findings all support the earlier proposal that setting caseload size was more important in terms of variations in standard of nursing care observed than was the size of the personal caseloads of these nurses.

As expected, in view of the significant correlation between care scores and contact duration, a significant negative correlation between the setting caseload size and the mean care score of to each setting was found (RHO = -0.66 p = <0.01). This confirms that higher care score contacts were observed in the settings with smaller caseloads, and that these also resulted in longer contacts. The previously established significant correlation between setting caseload size and care scores further supports the importance of the significant difference in setting caseload sizes between sectors. Previous findings have established that Sector Four settings, where care scores were significantly higher and contacts significantly longer, did have significantly smaller caseloads compared with the remaining three sectors.

Classification of Contacts and Standards of Nursing Care

In the Study Design and Methods chapter the basis of classifying contacts using the content of the field notes was described. The categories of; basic, social, structured, and directive were proposed and defined. These were not mutually exclusive so that a contact could be considered in terms of one or more categories. All

202 contacts were considered to be basic. Only seven of the 202 contacts did not meet the criteria for a social contact, so that during virtually all contacts nurses dealt with patients in a friendly and sociable manner. Of the 202 contacts, 136(67.33%) were additionally considered to be structured, but not directive, with only 41(20.30%) considered to be directive.

An analysis was undertaken by defining three contact groups from combinations of these categories. Excluded from this analysis is the single contact which was categorised as being directive but was not structured. The field notes show that this contact was only considered directive because the nurse concerned specifically instructed the patient to consult her GP regarding a drug related matter. Apart from this instruction the contact contained no other nursing interventions or systematic review beyond the administration of an injection.

Of the 201 remaining contacts a group of 65(32.24%) were classified as being basic or social but were neither structured nor directive. The 96(47.76%) contacts which were structured formed the second group and, finally, there were the 40(19.90%) contacts which were both structured and directive. Table 7 shows findings relating to each of these contact classification groups.

Table 7: Interventions, Mean Care and Mean Duration by Contact Type

	Basic/ Social	Structured	Structured/ Directive
Contacts	65	96	40
Mean Interventions per Contact	4.95	6.35	8.05
Injection Interventions(%)	80.75	60.46	27.33
Drug Related Interventions(%)	10.56	20.82	49.69
Other Care Interventions(%)	8.70	16.72	22.98
Mean Care Score	5.43	7.40	9.68
Mean Contact Duration(Minutes)	2.71	5.05	7.63

n = 201

Basic or Social Contacts

Sixty-five contacts were categorised as being basic or social only, and had a mean care score of 5.43. As Table 7 shows these contacts were predominantly injection orientated, in that over 80 percent of interventions involved giving injections. Marginally over ten percent of interventions were drug related and nurses failed to monitor compliance with oral medicines during 44 of the 65 contacts. During 62(95.38%) of these contacts nurses made no attempt to monitor drug side-effects. Other care interventions were particularly infrequent, accounting for only 28(8.70%) of the 332 observed interventions.

Structured Contacts

Ninety-six contacts were categorised as being structured. These contacts had a mean care score of 7.49. Compared with basic or

social contacts there was a reduced focus on injection giving, since only 381(60.46%) of the 610 interventions were ascribed to the injection category(Table 7). There was also more evidence of drug related interventions in that these accounted for over twenty percent of observed interventions, where the more frequent monitoring of drug side-effects was particularly apparent. However, nurses failed to monitor compliance with oral medicines during 48 of the 96 contacts.

Structured and Directive Contacts

These 40 contacts produced a mean care score of 9.68. Injection interventions accounted for less than half of the 322 interventions observed(Table 7). A further 88(27.33%) interventions were drug related, of which 60 involved the monitoring of drug side-effects and 28 compliance with oral medicines. Compliance with oral drugs was not monitored during 12 of the 40 contacts. The remaining 74(22.98%) interventions were those of the other care category. The proportion of drug related interventions was particularly notable, accounting for more than 27 percent of interventions compared with less than nine percent in the other two contact groups(Table 7).

Differences between Contact Groups

Analysis showed that the allocation of contacts to each of the three contact groups were significantly different in terms of care groups(Chi-Squared = 48.76 p = <0.001). As Figure 24 shows those contacts which were classified as being basic or social only were

FIGURE 24.

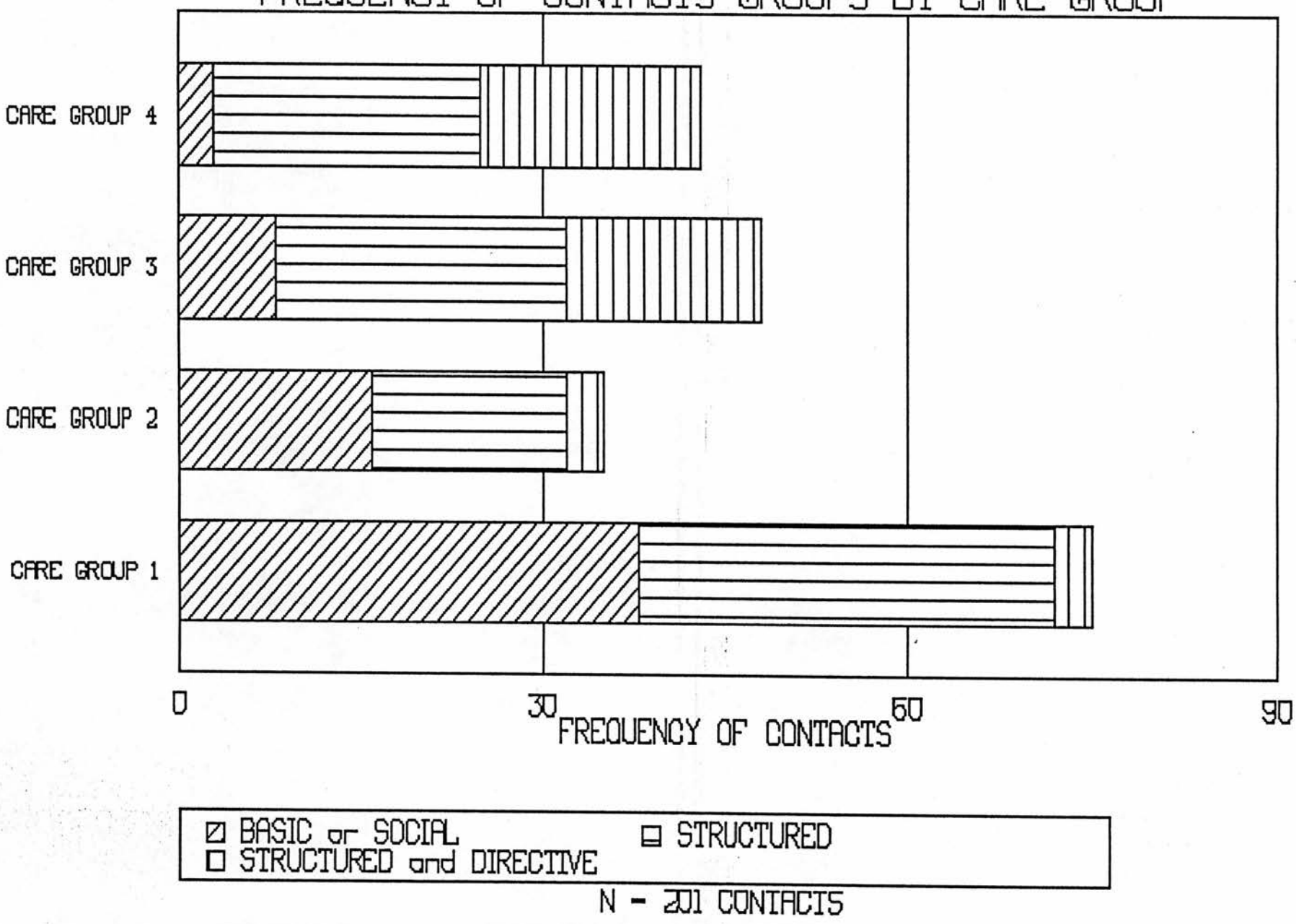
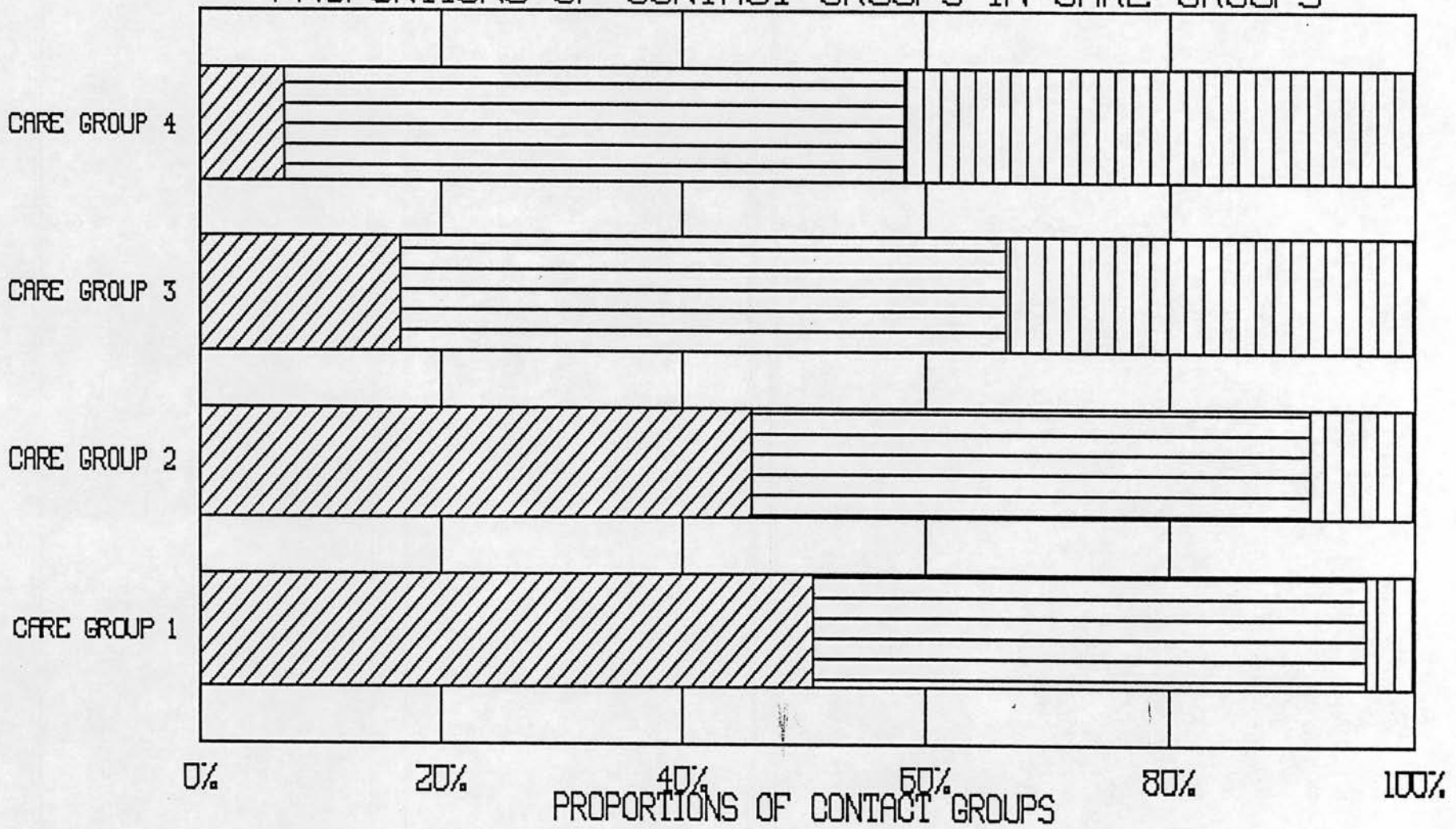

FREQUENCY OF CONTACTS GROUPS BY CARE GROUP
CARE GROUP 4
CARE GROUP 3
CARE GROUP 2
CARE GROUP 1
0
30
60
90
FREQUENCY OF CONTACTS
BASIC or SOCIAL
STRUCTURED
STRUCTURED and DIRECTIVE
N - 201 CONTACTS

FIGURE 25.

PROPORTIONS OF CONTACT GROUPS IN CARE GROUPS



N = 201 CONTACTS

mostly found in Care Groups One and Two, accounting for over 40 percent of contacts in those care groups. Conversely, contacts categorised as being structured or structured and directive were more apparent in the higher scoring Care Group Three and Four contacts, where basic or social contacts were comparatively infrequent. This is clearly illustrated in Figure 25, which shows the proportions of contact groups in each of the four care groups.

This is confirmed by the additional finding that care scores were significantly different between contact groups(KW = 50.46 p = <0.001), with the lowest care scoring contacts being more common to the basic or social contact group. Significant differences between contact groups were also found regarding drug related care scores (KW = 29.48, p = <0.001) and care scores arising from other care interventions(KW = 36.50, p = <0.001), indicating that these interventions were more frequently observed during the higher scoring structured contacts and structured and directive contacts(Table 7).

A further important difference in contact groups also occurred between sectors (Chi-Squared = 41.27 p = <0.001), as Figure 26 demonstrates. Compared with the remaining three sectors fewer contacts in Sector Four were classified as being only basic or social. The basic or social category applied to over 40 percent of all contacts in Sectors One, Two and Three, which contrasts dramatically with Sector Four where this category accounted for less than 10 percent of contacts(Figure 27). That Sector Four accounts for almost half of the structured contacts and structured and

FIGURE 26
FREQUENCY OF CONTACT GROUPS IN SECTORS

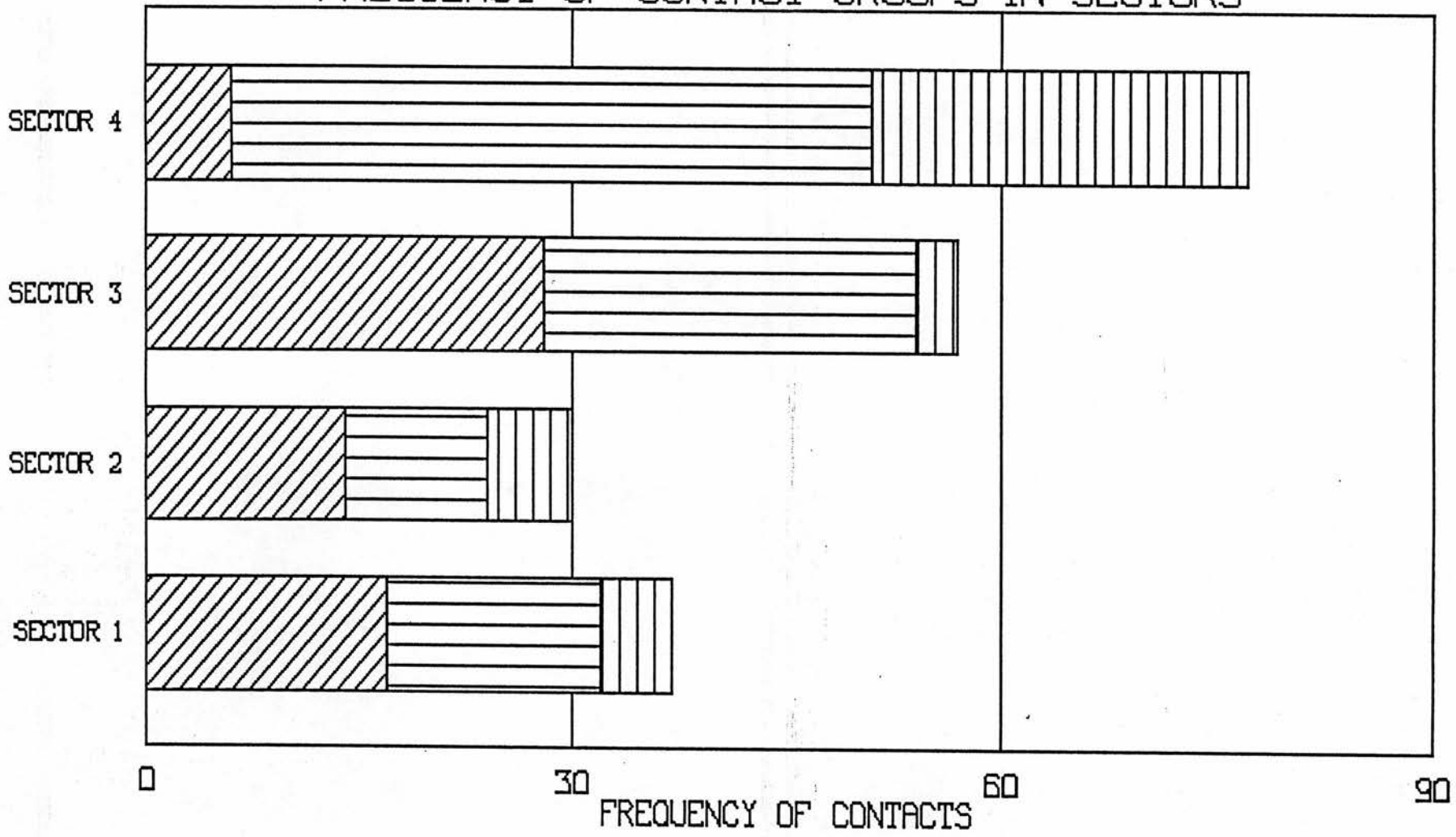
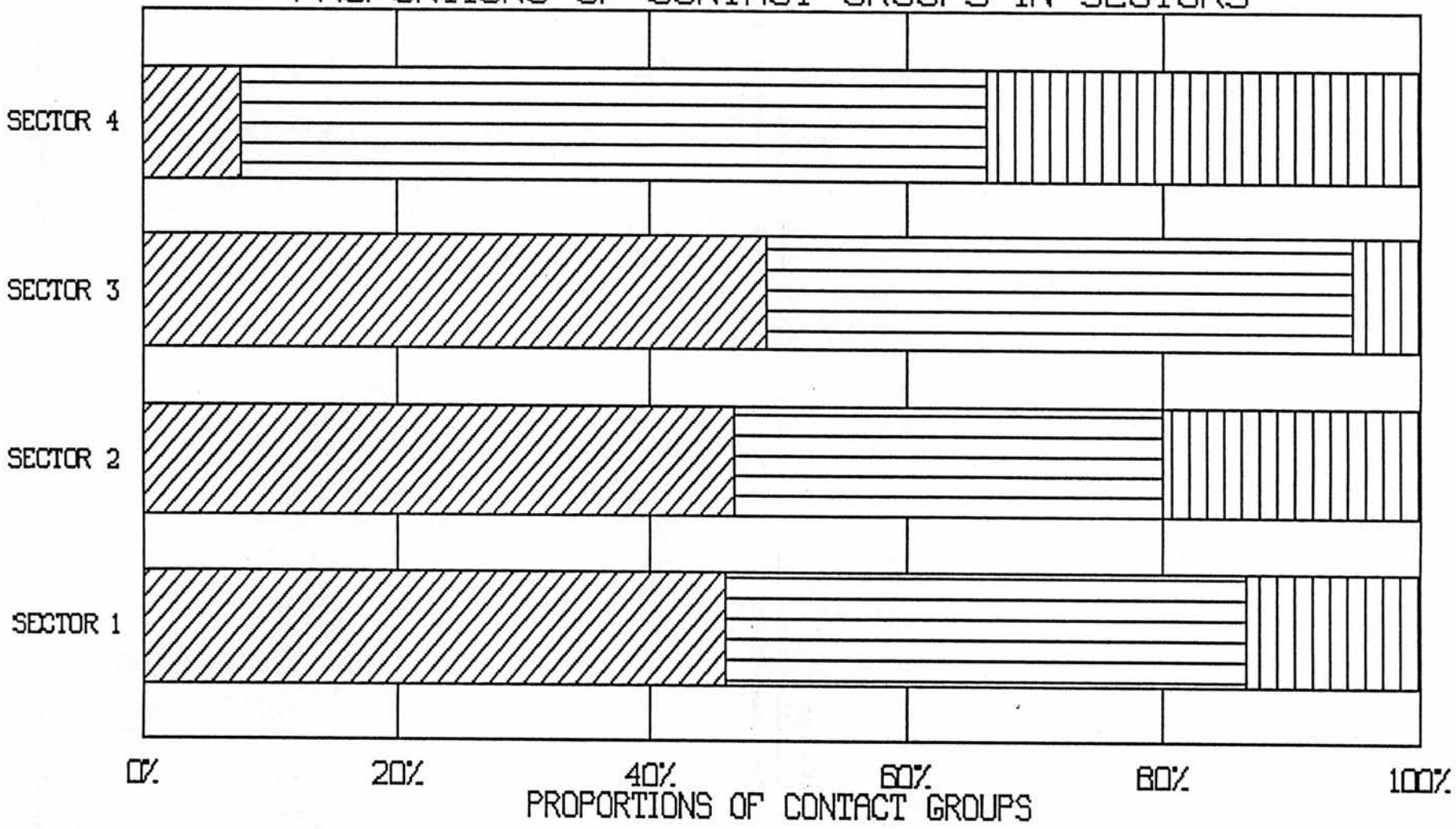


FIGURE 27.

PROPORTIONS OF CONTACT GROUPS IN SECTORS



directive contacts is further evidence of the better standards of nursing care and the increased emphasis on drug related interventions observed during contacts in this sector.

These findings indicate that the allocation of contacts to contact groups, and the field notes on which the allocation was based, successfully discriminated between variations in the observed standards of nursing care. While the field notes of almost all contacts contain evidence of socially appropriate exchanges between nurses and patients this alone does not constitute an adequate nursing contribution to patient care. The limited number and range of interventions observed during the 65 basic or social contacts confirm a preoccupation with injection giving.

The structured contacts did involve a more systematic review of patients needs but contained limited evidence of nurses taking positive action beyond making general enquiries and giving support and encouragement. The structured and directive contacts were more purposeful but, as the field notes reveal, many of the instructions nurses gave to patients were drug-related, usually telling them to contact their GP or Consultant with regard to their prescribed drug regime or worries about drug side-effects.

CHAPTER SEVEN

Organisational Climate and Standards of Nursing Care

The climate findings are based on the responses to the instrument obtained from each of the 17 participating nurses. This data can be analysed in two distinct ways. First, by analysis of the 17 individual responses and, secondly, by considering that each of the 202 depot drug contacts occurred under the climate conditions reported by the nurse concerned. As proposed in chapter three the range of organisational characteristics described by nurses are viewed as having influenced the standard of nursing care observed during each contact.

Only the differences between managerial sectors and care groups are addressed in the presentation of climate findings. This accords with earlier finding that the most significant difference in care scores occurred between sectors, and since analysis revealed that climate scores were not significantly different between the three grades of nurse. The significant difference found in climate scores between the three types of setting is not explored because this also occurred primarily as a consequence of the location of majority of health centre settings in Sector Four.

Nurses Opinions of Organisational Characteristics

The earlier discussion highlighted the debate concerning climate and job satisfaction. The former is essentially a descriptive concept while the latter is affective in nature. Any apparent empirical similarity is a consequence of the inclusion of affective items in some climate instruments. In view of this debate the climate instrument developed for use in this study separated the descriptions of organisational characteristics from the opinions of nurses about them.

In completing the climate instrument nurses were first asked to describe whether or not a particular organisational characteristic was a feature of their organisational environment. They were then asked to indicate their personal view regarding each of these on a continuum from 'Unimportant' to 'Essential'. Analysis of these data revealed no significant differences in the visual analogue scores for either individual items or section scores between any of the groupings in the sample.

Therefore, the opinions of these nurses regarding the organisational issues explored were similar. They regarded these issues as being important, since only four of the 30 items produced a mean score of less that five (from a maximum score of seven). Further analysis revealed that while some significant differences in the descriptive climate section scores were found these were not accompanied by significant differences in the related visual analogue scores.

Whilst these nurses held similar opinions regarding the importance of the organisational issues addressed in the climate instrument the extent to which they then described these same issues as being factors in their organisational environments was more variable. This suggests that the descriptive and affective responses obtained using the climate instrument are measures of separate aspects of the nurses involvement with the organisation.

Climate Instrument Scores and Managerial Sectors

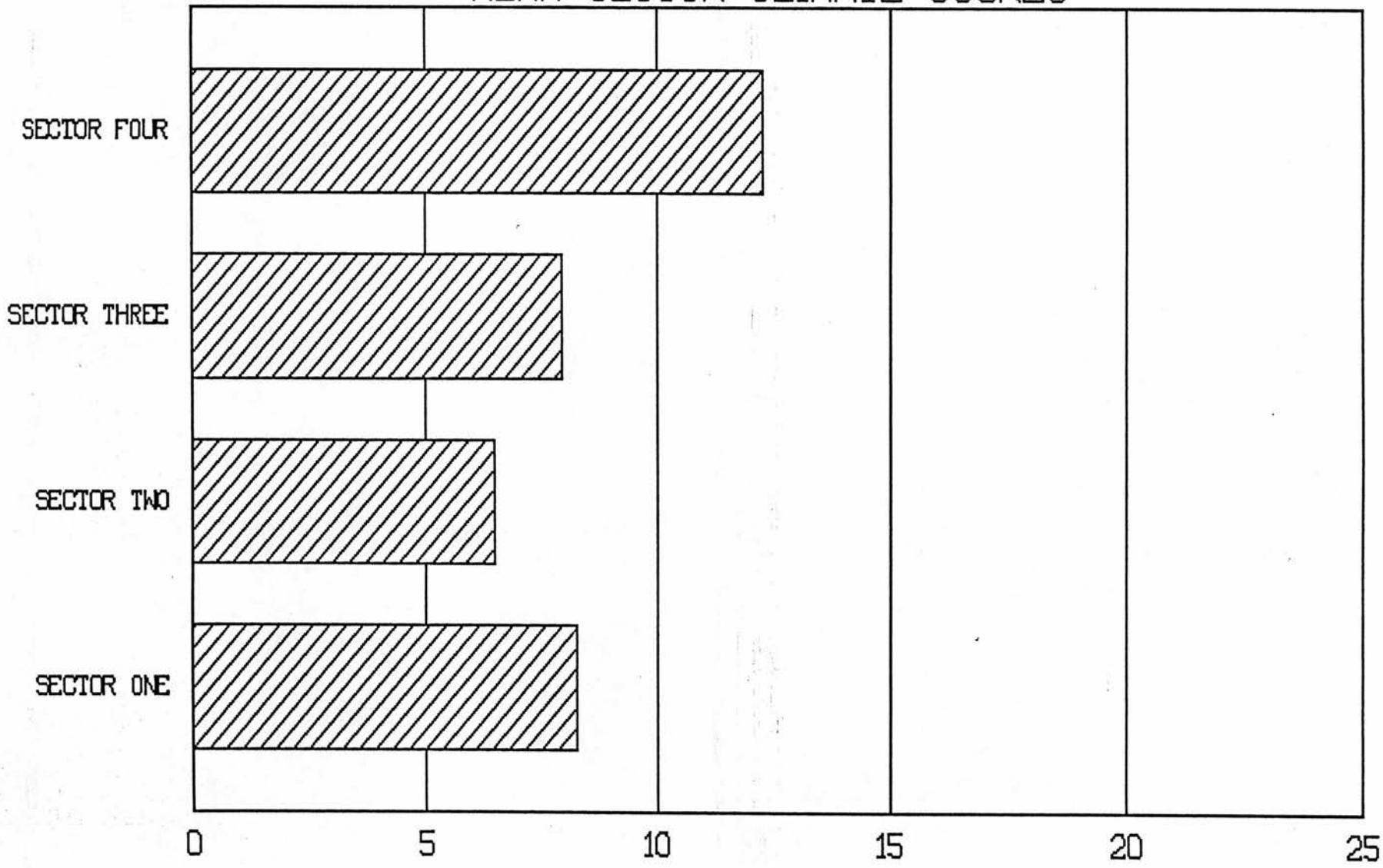
Introduction of New Ideas and Innovation

All 17 nurses felt that they were encouraged to suggest new ideas and that routine meetings were the usual fora for making suggestions. Thirteen indicated that new ideas would be still be considered even if there was a degree of risk involved. Of those who indicated that implementing new ideas was unlikely where some form of risk was involved some cited a lack of managerial commitment in these situations because, as one nurse suggested, "**management tend to be cautious and are insecure because they have less practical knowledge of 'out there'**". Another CPN observed that some nurses might not enjoy the responsibility inherent in taking risks since this "**would put you up front and make you accountable**".

Only the eight nurses based in Sector Four indicated that any new ideas discussed might subsequently be implemented. However, in their comments, they imply that any innovation was more often due to the efforts of individual nurses rather than their managers and, as one nurse noted, implementing new ideas was "**often done without the involvement of management, but management generally approve unless there are resources required.**" Others made similar comments and also stressed that the likelihood of implementing new ideas was reduced if additional resources would be required.

Sixteen of the 17 nurses indicated that they were, on occasions, able to break or ignore defined rules and procedures. This was mainly because

FIGURE 28
SECTION 1: NEW IDEAS AND INNOVATION
MEAN SECTOR CLIMATE SCORES



N - 17 NURSES

their failure to comply with some rules was unlikely to be noticed by their managers. Fourteen described rarely receiving any form of reward and recognition for their efforts, although some did note that their peers sometimes showed an appreciation of effective nursing. They again cited a lack of awareness amongst managers regarding what they actually did as the principal reason for this lack of praise or recognition.

The scores from this section ranged from 4.73 to 15, with a mean of 10.10(sd 3.16). Sector scores were significantly different (KW = 12.21 p = <0.01) and are reflected in the respective mean sector scores shown in Figure 28, which also reveals that the higher scores were found in Sector Four. However, taking into account the range of scores found and the potential maximum score of 21, the findings reveal that the climates experienced by these nurses were only moderately orientated towards innovation.

Effective Organisation of Nursing Activity

The responses here were particularly variable. All 17 nurses described being involved in most day to day decisions affecting their activities. They again reveal that this a further consequence of the general absence of managerial involvement in clinical matters which resulted in nurses having autonomy in planning their clinical work. One nurse describes this in commenting that **"very little work is imposed and I arrange my own schedule and, therefore, decide my own priorities."** Another noted that clinical autonomy **"is inherent in a CPN's work; as they assess the client, then decide on a care plan, the frequency of visits and discharge arrangements."**

Ten nurses, including all eight from Sector Four, indicated that some nursing procedures were the subject of written policy statements. The remainder felt that clinical issues were not prominently reflected in formal policies. However, all the comments indicate that most formal procedures concerned managerial or administrative matters. Five nurses described having insufficient information in relation to their daily activities and some suggested that information might be withheld from them or that different interpretations were sometimes made of the same information. While some felt that information was adequate they again noted that managerial information was often deficient compared with clinical information.

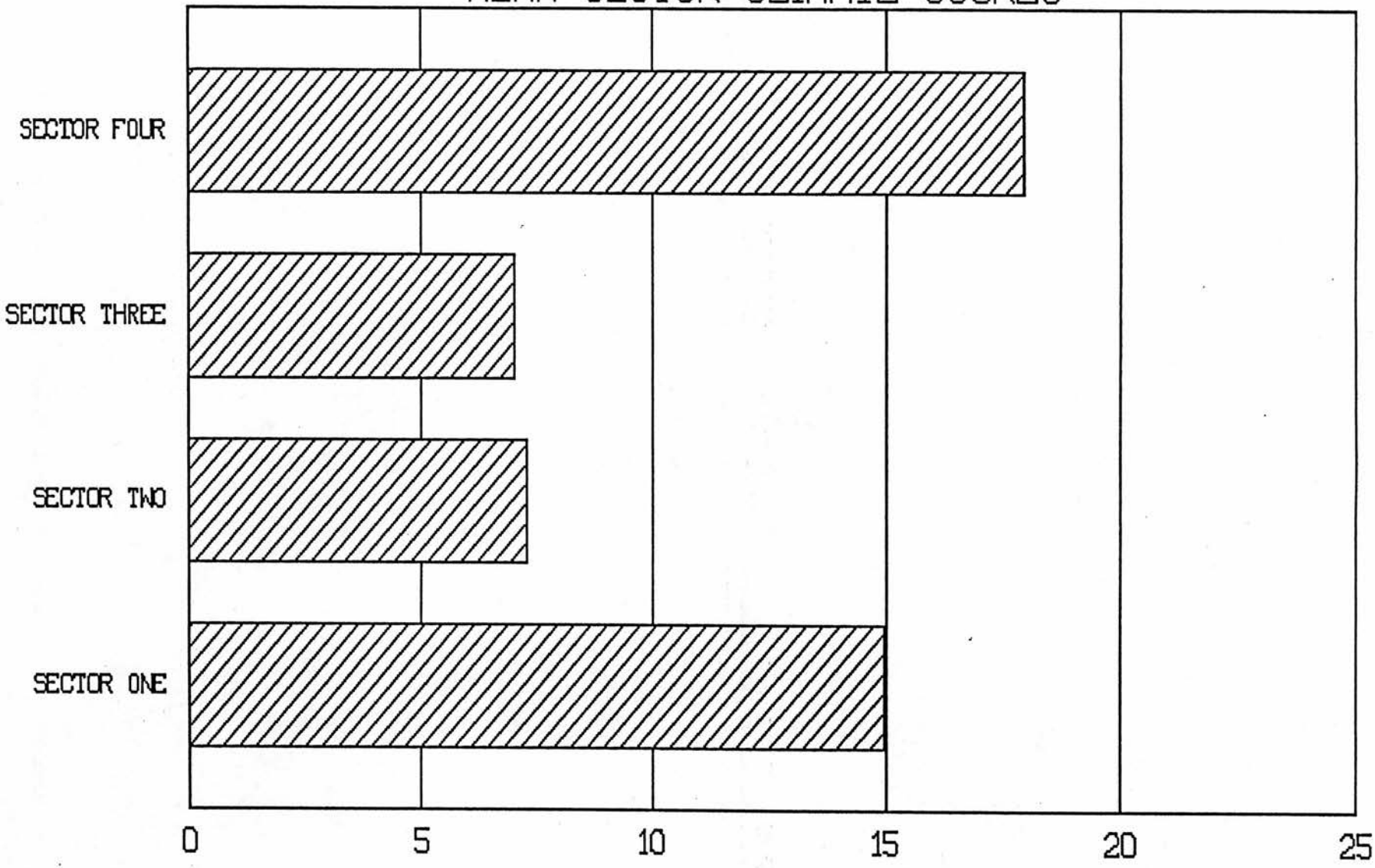
Nine nurses indicated that there were often delays in decision being made. Their comments suggest that this was mainly due to the actions of their managers. One noted that **"delays are usually caused by people exercising their authority - and wanting to be seen doing so."** This is echoed by another who felt that there were **"too many managers - all wanting to be consulted."** Twelve of the 17 nurses described delays in communications and, again, their comments suggest that communications regarding clinical matters were less problematic than managerial communications. Some pointed out this was mainly because they were most directly and personally involved with clinical information.

Sector scores were again significantly different (KW = 11.92 p = <0.01) and ranged from five to 21, with a mean of 13.93(sd 5.92). The higher scores were found in Sectors One and Four, as the mean scores shown in Figure 29 confirm. These findings indicate that issues such as

FIGURE 29

SECTION 2: ORGANISATION OF NURSING ACTIVITY

MEAN SECTOR CLIMATE SCORES



N - 17 NURSES

communication with others, the availability of information, and prompt decision making, were most effective in these sectors.

Roles of Nursing Staff

Only four of the 17 nurses indicated that they had an accurate and current job description, and a number commented that their job descriptions bore no relationship to their duties. Only one nurse, who was directly supervised by a fieldwork teacher, indicated that he took instructions exclusively from his nurse manager. The remaining nurses all described taking instructions from a variety of sources, and especially from medical staff. Although many acknowledged a formal requirement to seek the approval of their nurse managers, whom they again stressed were not regularly involved in clinical matters. As such routine clinical issues were not discussed with them and only more urgent matters of concern, such as mistakes or possible complaints, were raised with nurse managers with any urgency. As one nurse noted; **"there is close contact with medical staff regarding the important clinical decisions. Nursing management is much less involved."**

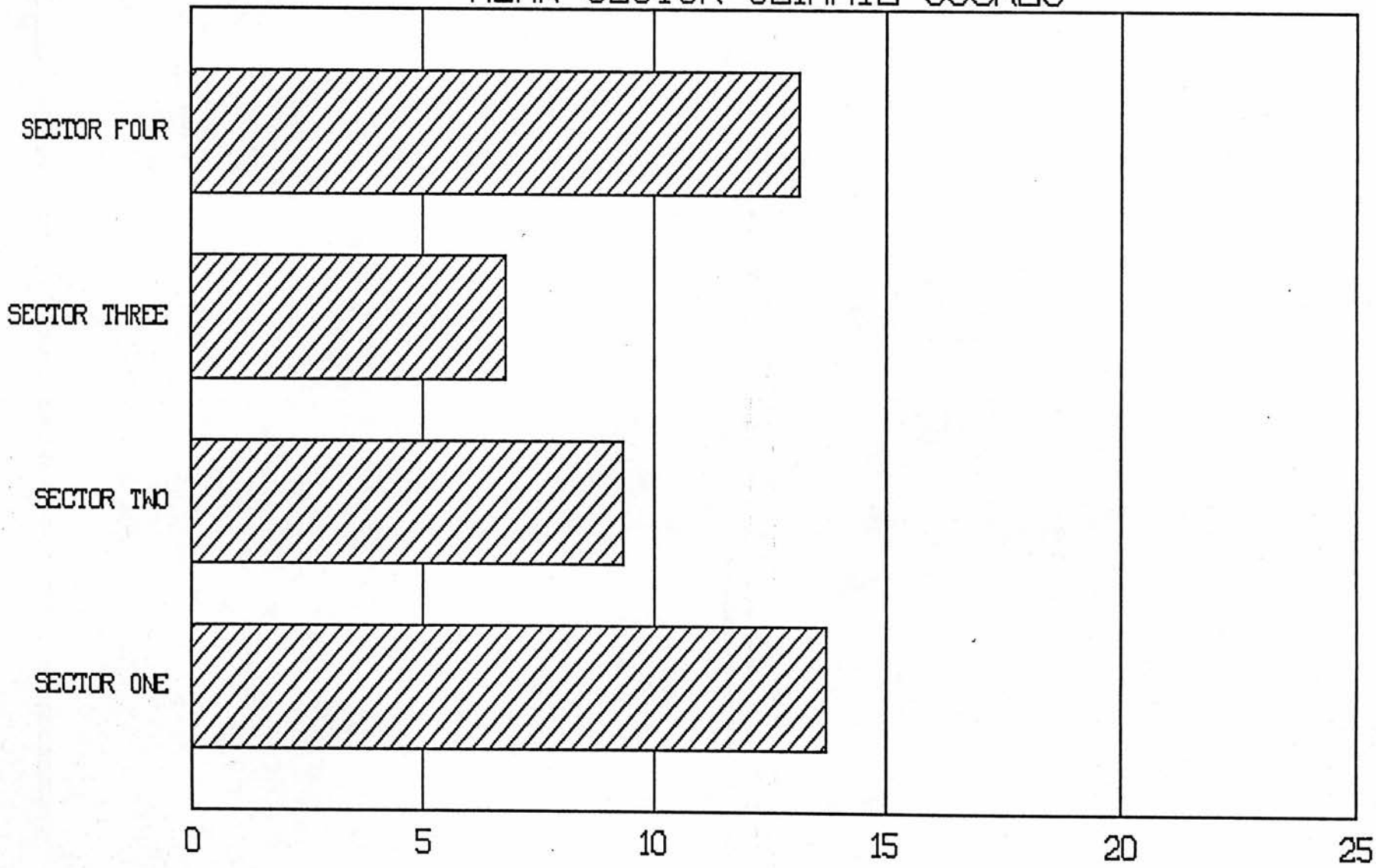
Fourteen nurses considered that the demands made on them were compatible with their job. Their comments suggest that they were not particularly restrictive regarding what they considered to be a nursing issue as long as there were some potential benefits for patients. Only three nurses considered that some of the demands made of them were wholly incompatible with their role and even then their concerns related mainly to the number of demands made of them rather than the content. Only one nurse described receiving inappropriate demands and raised the issue of

confusion regarding the role of CPNs, commenting that **"I am often given inappropriate referrals, such as social problems without a psychiatric background. Some GP's aren't sure of the difference between a CPN and a Community Nurse."** Fifteen of the nurses observed that although they had autonomy in defining their clinical workload priorities they had less influence in managerial matters.

Ten nurses described being able to respond to most of the demands made of them. They again indicated that the number of demands was the most important issue and that they would always attempt to meet these. In the comments of the seven nurses who stated they they could not always satisfy demands they cited excessive levels of demand on their services as the reason for this. One nurse noted that **"because of the way work is organised dealing with any emergencies, or extra work, means that other work has to be postponed."**

Only eight of the 17 nurses considered that they currently had all the skills and knowledge required to perform the activities expected of them. All but one of these nurses had gained a post-basic qualification in this specialty. Comments from the nurses who felt that they did not have all the skills required to deal with many of the problems they regularly encountered suggest that they were involved with a variety of clinical issues, such as sexual counselling, which they had adopted as part of their role. From their earlier comments it is possible that managers, who were responsible for organising training, may not have been fully aware of the extent of nursing involvement in some of these activities.

FIGURE 30
SECTION 3: ROLES OF NURSING STAFF
MEAN SECTOR CLIMATE SCORES



N - 17 NURSES

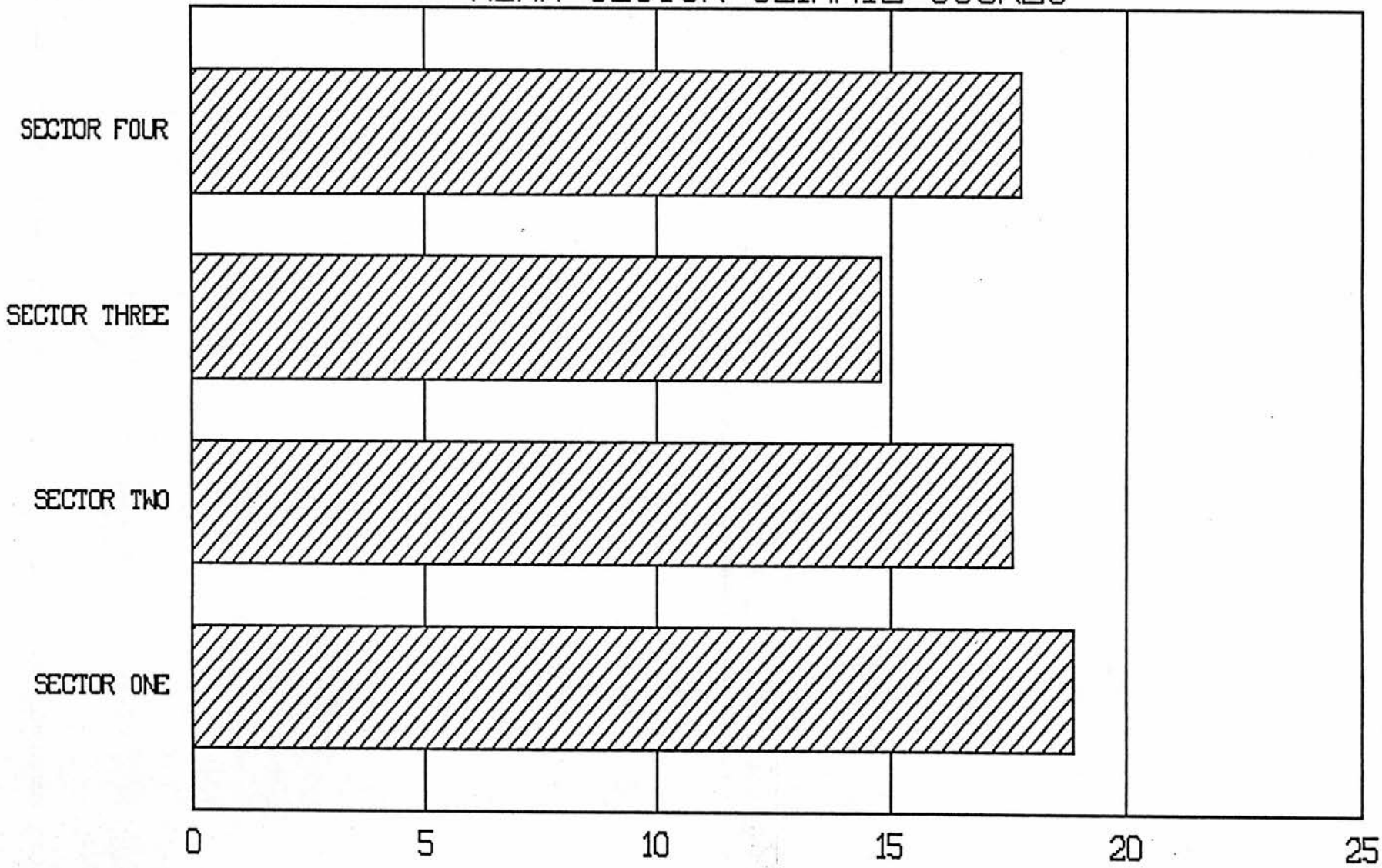
The scores for this section ranged from three to 18.25, with a mean of 10.97(sd 4.96). The sector scores were not significantly different but were notably lower in Sectors Two and Three, as the mean scores shown in Figure 30 demonstrate. This lack of a significant difference between Sectors implies that the roles and responsibilities of these nurses were similarly, if often inaccurately, defined.

Warmth and Support at Work

All 17 nurses indicated working relationships were informal and that people were generally supportive if they had a problem. Only three nurses noted that they had ever experienced a lack of trust amongst colleagues and only two complained of a lack of team spirit at work. In terms of the availability of guidance and advice only five nurses indicated that this was rarely offered, again citing the lack of managerial involvement in day to day activities as the reason for this.

The issue which proved the most variable in this section was the manner in which mistakes were handled. Nine nurses described that mistakes were handled in a constructive manner. The remaining eight nurses all indicated that the allocation of blame was the preoccupation of management when mistakes occurred. One nurse commented that **"management needs to assume, perhaps to show that they are managing, that someone must be seen to be at fault and they should expect to be punished if the fault was serious enough."** To some extent nurses may have been referring indirectly to specific events but their responses suggest that they found managers were more inclined to assert their authority when mistakes occurred.

FIGURE 31
SECTION 4: WARMTH AND SUPPORT
MEAN SECTOR CLIMATE SCORES



N - 17 NURSES

The scores for this Climate section ranged from 6.08 to 21, with a mean of 17.24(sd 4.77). These scores were not significantly different between sectors and three of the sectors having similar mean scores (Figure 31). With the exception of the manner in which mistakes are dealt with these nurses tended to experience similar levels of Warmth and Support at work so that this aspect of climate was relatively stable irrespective of significant variations in other organisational characteristics.

Standards of Nursing Care

Only three nurses felt that standards of nursing care were not regularly discussed. The comments from the remaining nurses suggest that while standards of nursing care were be discussed not all were enthusiastic regarding this topic. One nurse noted that standards were; **"discussed with regular monotony."** and another that standards were; **"flavour of the month because of the white paper."** Others also noted that standards were a particular preoccupation of managers.

All 17 indicated that nursing care was based upon individual care plans. Most commented, without great enthusiasm, on the imminent introduction of a new standardised Care Plan by nursing management. The comments also revealed that there was no regular monitoring of the standards of nursing care they provided, although some stated that they would welcome this. Another noted that the only monitoring she was aware of was the size of CPN caseloads.

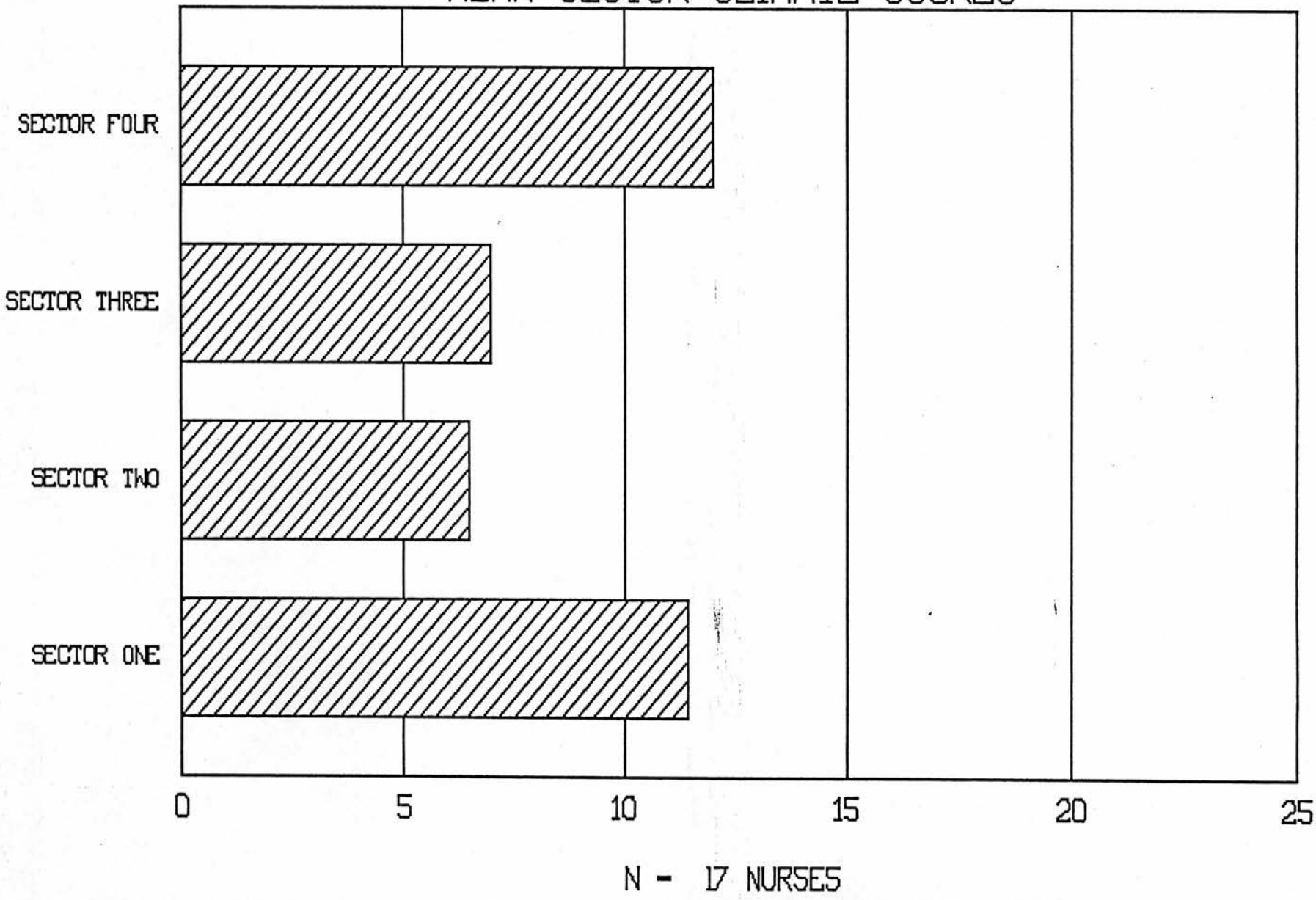
Eleven nurses indicated that the organisation took no active steps to update them with clinical or professional developments, although several

emphasised that they did so on a personal level. Of the six nurses who did describe being updated by the organisation five were based in Sector Four. Sixteen of the 17 nurses described having insufficient resources to achieve a high standard of nursing care. Large caseload sizes, a lack of secretarial support, and no resources for training, were the most frequently cited issues. The single nurse who did feel that sufficient resources were available was working under the direction of a fieldwork teacher and noted that his remit was restricted.

Six nurses indicated that expected standards of nursing care had not been defined. These six nurses comprised of all those based in Sectors Two and Three. Conversely all 11 nurses based in Sectors One and Two did describe having some defined standards of nursing care, although they also noted that these were at an early stage. Some doubt was expressed regarding the reasons for developing formally defined standards, with one nurse suggesting that standards; **"were developed simply because managers were required to have standards of care defined."**

The scores for this Climate section ranged from 4.75 to 14.13, with a mean of 10.19(sd 3.10). Sector scores were significantly different (KW = 11.67 p = <0.01) as the mean scores shown in Figure 32 confirm. The range of scores indicate that standards of nursing care were, at best, minimally defined, particularly so in Sectors Two and Three. At the time of the study the nurses reported that no formal procedures to monitor standards of nursing care were being used within the study area.

FIGURE 32
SECTION 5: STANDARDS OF NURSING CARE
MEAN SECTOR CLIMATE SCORES

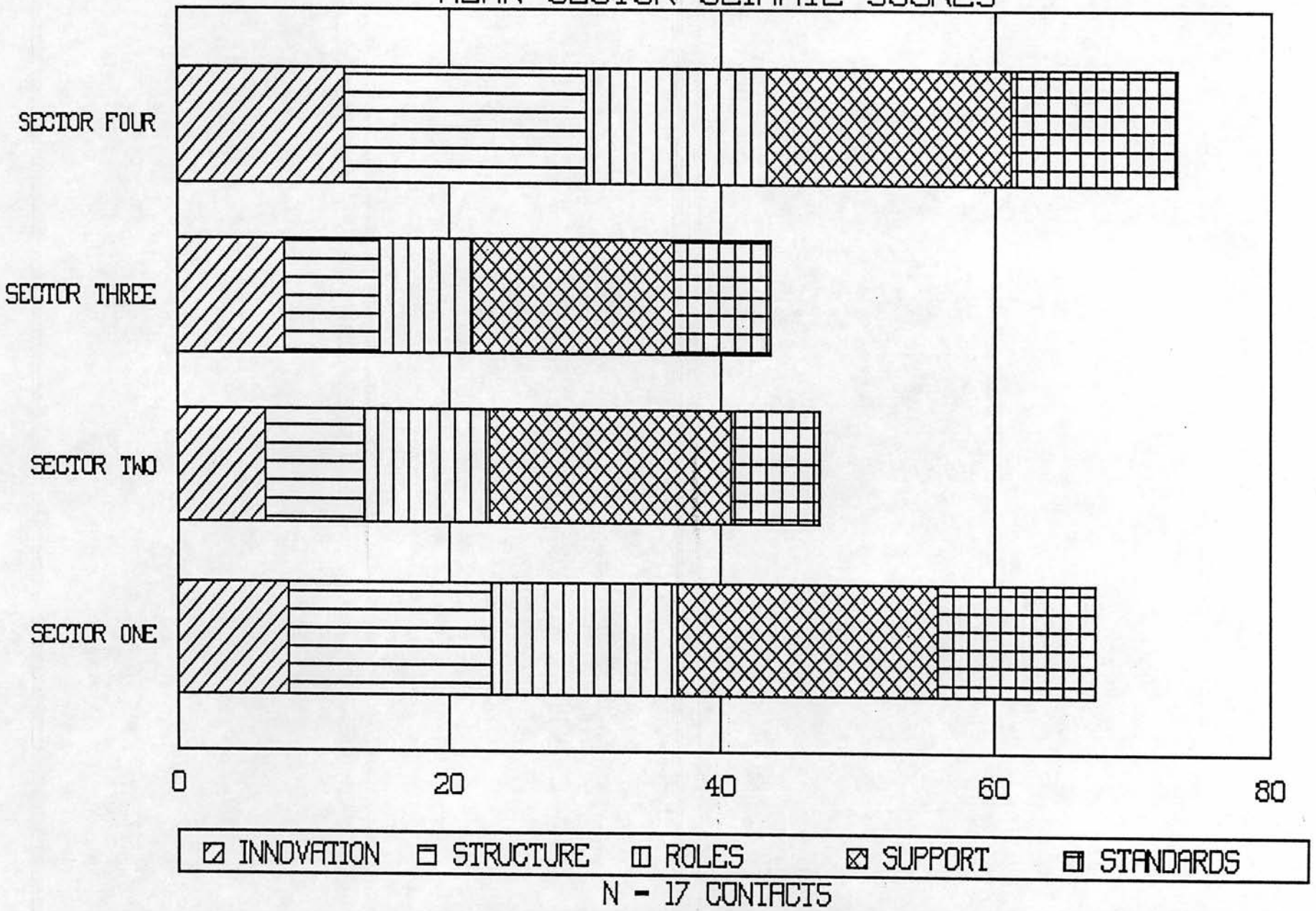


Global Climate Scores

The global climate score attributed to each nurse is the sum of the five section scores ranged from 31.72 to 82.92, with a mean of 62.44(sd 16.01). The only significant difference in these scores was found between sectors (KW = 11.69 p = <0.01). As Figure 33 shows the global climate scores were similar between Sectors One and Four and between Sectors Two and Three. In effect Sectors One and Four had climates where the various organisational characteristics addressed in three sections of the instrument were significantly more evident than in Sectors Two and Three, with the highest scores occurring in Sector Four.

These findings suggest that each of the sectors can be considered as a separate organisation in that each had an identifiable climate where some components of these climates were significantly different between sectors. The issues of roles and responsibilities and working relationships were relatively stable aspects of the organisational environment of all four sectors. However, organisational characteristics relating to innovation, structural factors, and an emphasis of standards of nursing care were significantly more evident in Sector Four and, to a lesser extent, Sector One. In contrast these issues were less comprehensively described by the nurses working in Sectors Two and Three.

FIGURE 33
MEAN SECTOR CLIMATE SCORES



N - 17 CONTACTS

Climate Instrument Scores and Standards of Nursing Care

The climate findings presented so far are those resulting from the analysis of the 17 individual responses. The relationship between climate and standards of nursing care can also be explored from the perspective of the prevailing climate influencing each contact. This data can be analysed in terms of both differences in climate scores between care groups and the degree of association between the care and climate scores of each contact.

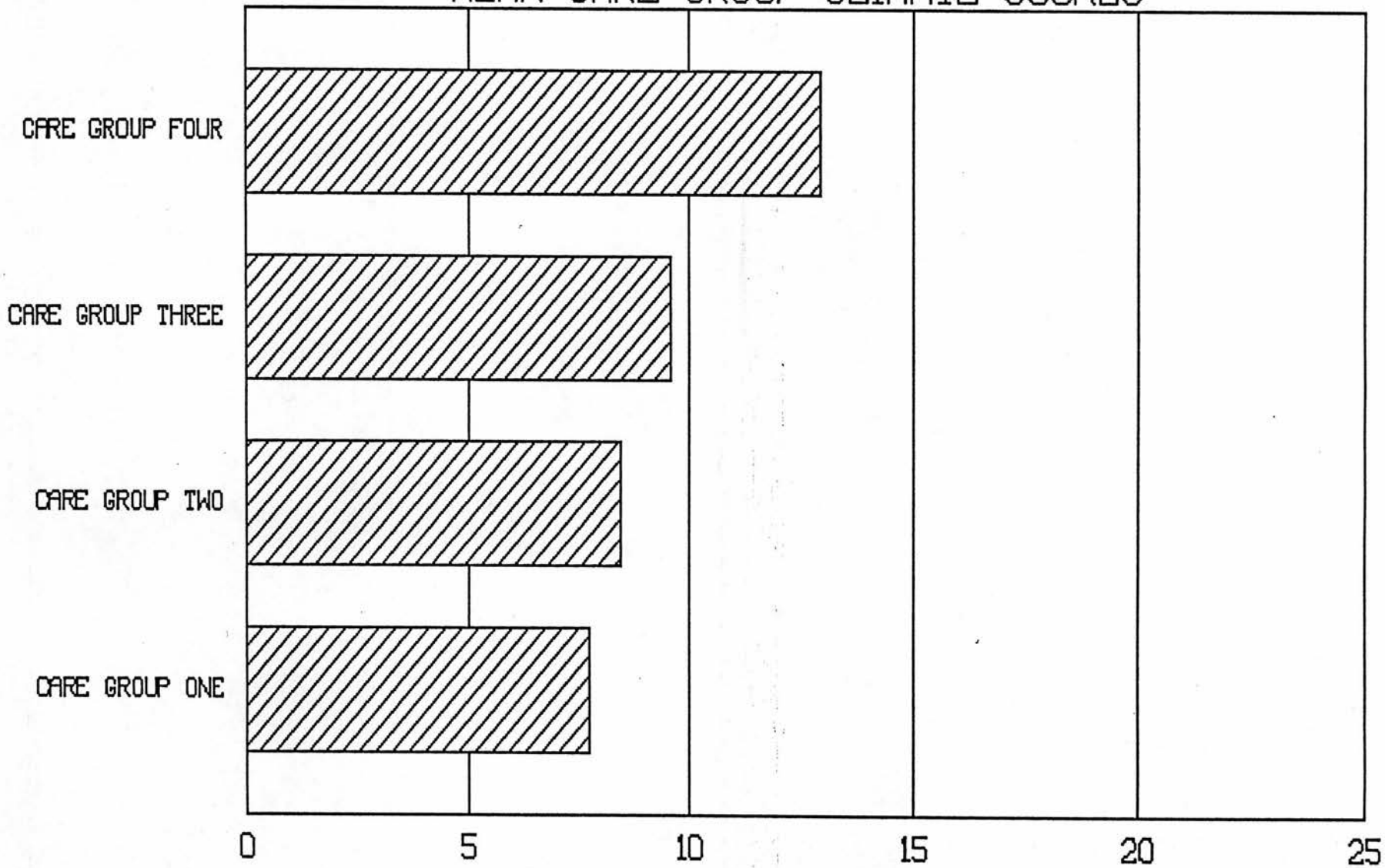
Introduction of New Ideas and Innovation

Climate scores for this section were significantly different between care groups (KW = 76.14 p = <.001). The higher scores were found in Care Group Four, which contained the highest care score contacts. This is confirmed by the significant positive correlation between climate scores from this section and the care scores of contacts (RHO = 0.57 p = <0.01). These findings confirm that the better standards of care were observed of nurses who reported they felt able to innovate and described a positive response to the introduction of new ideas. Figure 34 shows that in Care Groups One, Two and Three the mean scores from this section were similar but were substantially greater for Care Group Four contacts.

Effective Organisation of Nursing Activity

These scores were also significantly different between care groups (KW = 73.24 p = <0.001) and there was again a significant positive correlation

FIGURE 34
SECTION 1: NEW IDEAS AND INNOVATION
MEAN CARE GROUP CLIMATE SCORES



with care scores (RHO = 0.63 p = <0.01). Both these findings indicate that the better standards of care were observed by nurses who reported the most effective practices regarding structural issues such as communication and decision making. This is also illustrated in Figure 35, which shows progressively greater mean climate section scores as care scores increase.

Roles of Nursing Staff

While the scores were significantly different between care groups (KW = 19.82 p = <0.01) no significant correlation with care scores was found. This suggests that those nurses who reported more clearly defined roles and felt able to respond to many of the demands made of them did tend to exhibit the better standards of nursing care observed. However, the absence of a significant correlation with care scores suggests that issues of role, whilst significant, were of lesser importance than the other organisational characteristics addressed in the climate instrument. The mean climate scores for this section, shown in Figure 36, illustrate that these scores were relatively stable.

Warmth and Support at Work

The scores for this section were significantly different between care groups (KW = 11.56 p = <0.01) but were the least variable of the five sections as the similar mean scores shown in Figure 37 confirm. Additionally, these was also no significant correlation with care scores. However, in view of the absence of a significant difference in these scores between individual nurses this finding should be

FIGURE 35

SECTION 2: ORGANISATION OF NURSING ACTIVITY

MEAN CARE GROUP CLIMATE SCORES

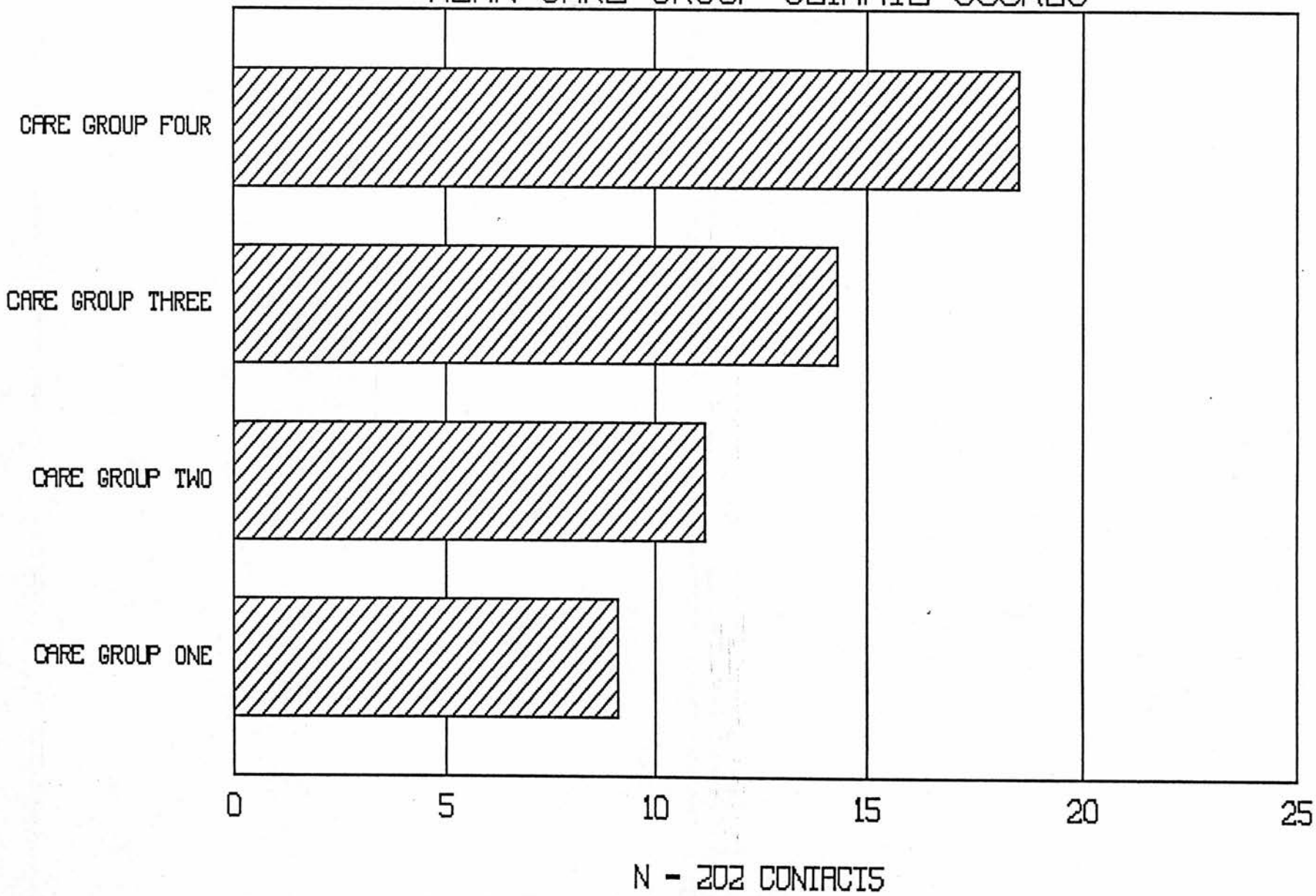
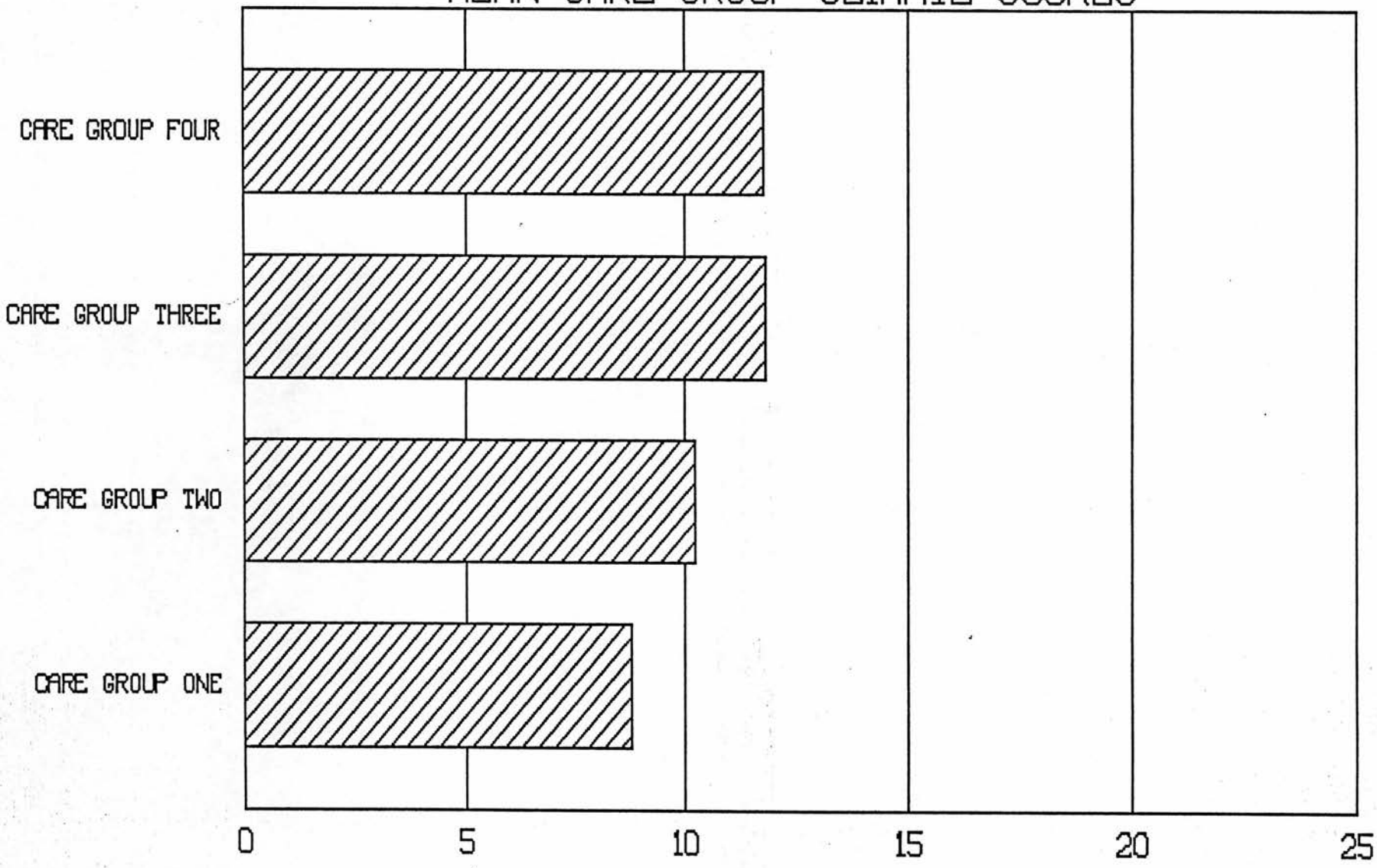
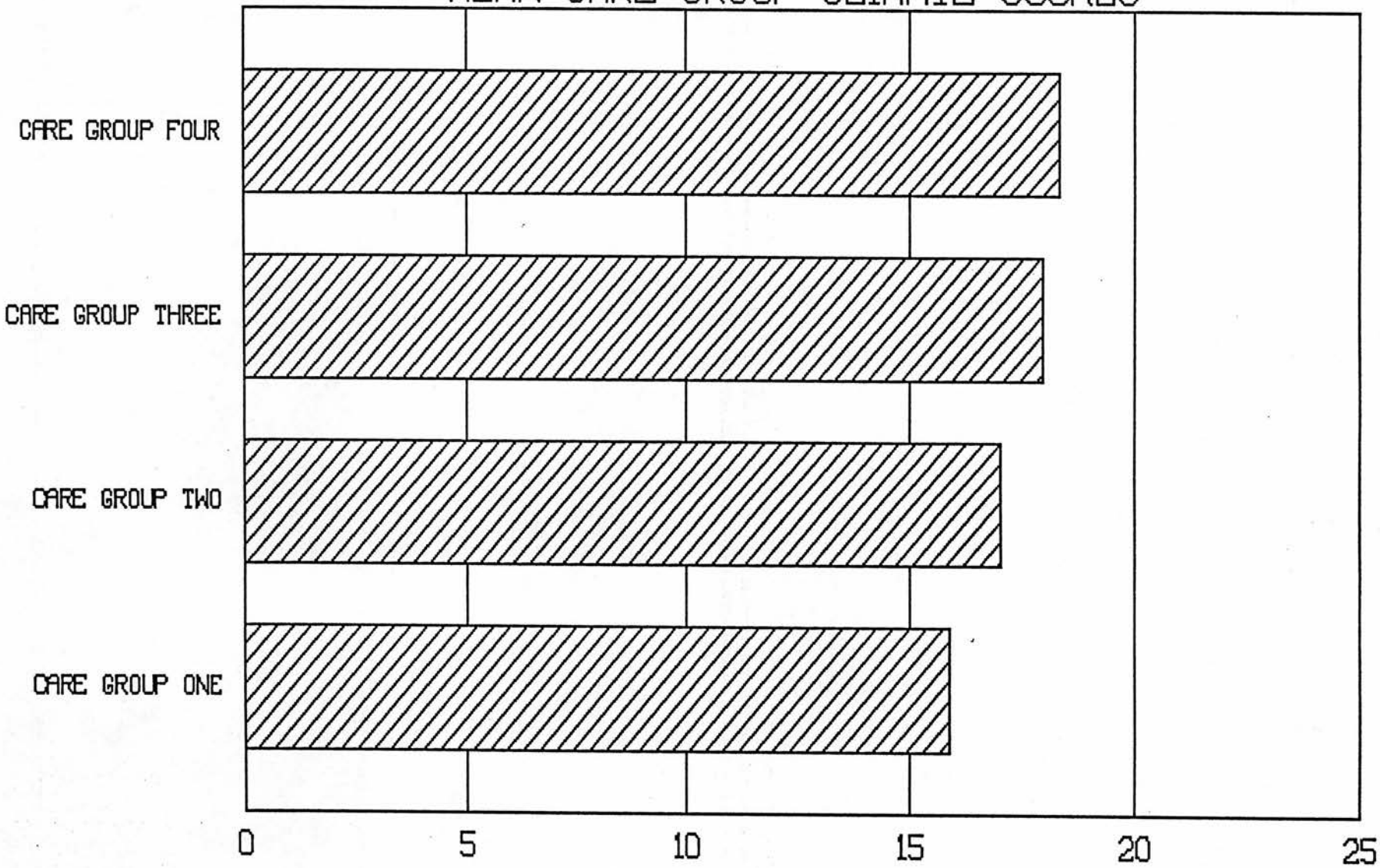


FIGURE 36
SECTION 3: ROLES OF NURSING STAFF
MEAN CARE GROUP CLIMATE SCORES



N - 202 CONTACTS

FIGURE 37
SECTION 4: WARMTH AND SUPPORT
MEAN CARE GROUP CLIMATE SCORES



N - 202 CONTACTS

viewed with caution. The significant difference found between care groups is a consequence of two nurses with the lowest scores for this section also accounting for low care scores, with most of their contacts being allocated to Care Groups One and Two. Both nurses were based in Sector Three where care scores were found to be significantly lower than in other sectors.

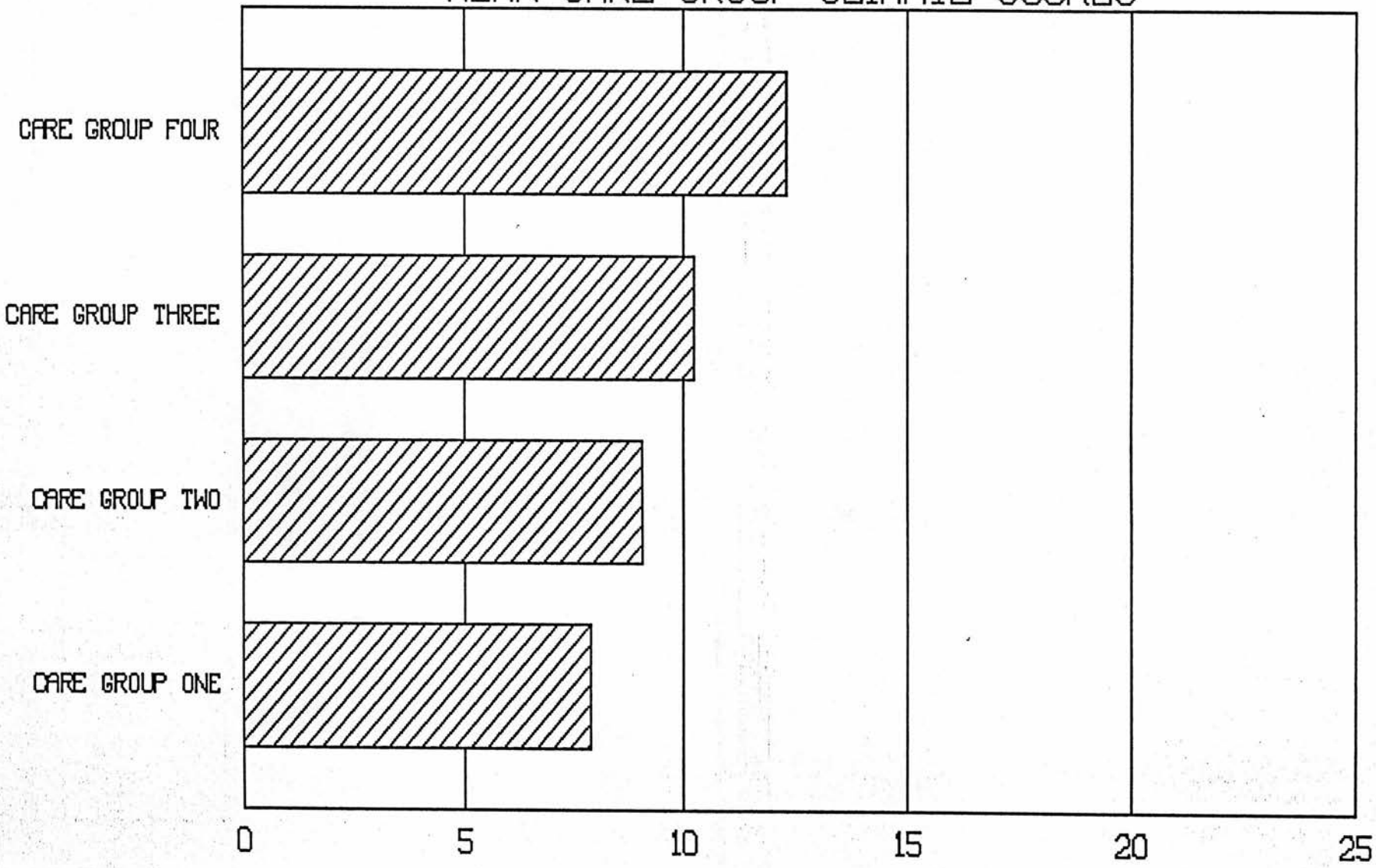
Standards of Nursing Care

These scores provided both a significant difference between care groups (KW = 58.50 p = <0.001) and a significant positive correlation with care scores (RHO = 0.52 p = <0.01). This is illustrated by the greater mean climate scores for Sectors One and Four shown in Figure 38. Both these findings confirm that where standards of care were an issue in the organisational environments experienced by nurses the observed standards of care they exhibited during depot drug contacts were better.

Global Climate Scores

The mean global climate scores for each care group in shown in Figure 39. While, and to varying degrees, climate section scores tended to increase along with care scores, the range of section scores clearly illustrate the significant differences in emphasis between care groups. In Care Group One, the lowest care score contacts, the climate scores indicate that Section Four accounted for a largest part of the global climate score. This is largely because the other section scores indicate that there is only minimal evidence of the other organisational characteristics influencing these contacts.

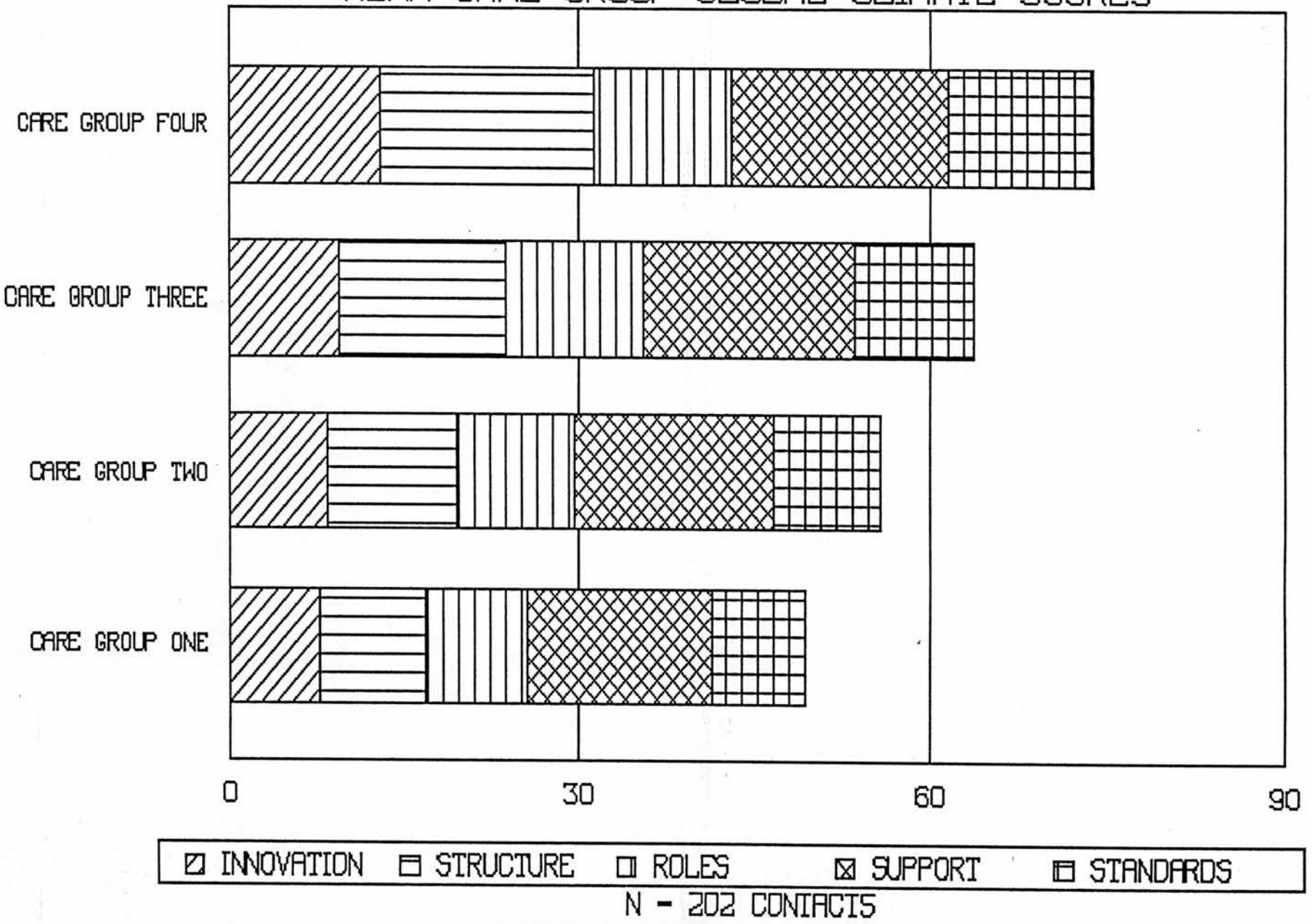
FIGURE 38
SECTION 5: STANDARDS OF NURSING CARE
MEAN CARE GROUP CLIMATE SCORES



N - 202 CONTACTS

FIGURE 39

MEAN CARE GROUP GLOBAL CLIMATE SCORES



For the slightly higher standard of care contacts in Care Group Two the section scores are marginally greater but remain similar to those of Care Group One contacts, compared with which only the Section Two scores were significantly different ($U = 1023.5$ $p = 0.046$), although the level of significance is uncomfortably close to 5 percent. As care scores increase during Care Group Three contacts there is evidence of a greater emphasis on innovation and structural characteristics in that Section One and Two scores were both significantly different compared with Care Group Two ($U = 622.03$ $p = 0.03$; and $U = 574$ $p = 0.013$ respectively).

For Care Group Four contacts the mean section scores were higher than for the three remaining care groups(Figure 39). This confirms that a wider range of organisational organisational characteristics were features in the climates of nurses exhibiting the highest standards of nursing care observed. Scores from three sections of the climate instrument were significantly different compared with Care Group Three; Section One, $U = 365$ $p = <0.01$; Section Two, $U = 581.5$ $p = <0.01$; and Section Five, $U = 681$ $p = <0.01$.

That climate scores did tend to increase along with care scores is further confirmed by the significant positive correlations between care and the climate scores for three of the five sections of the instrument. Returning to the individual responses of the 17 nurses correlating the mean care scores for each nurse with the climate section scores also resulted in significant positive correlations for the same three Sections; Section One, $RHO = 0.74$ $p = <0.001$; Section Two, $RHO = 0.80$ $p = < 0.001$; Section Five, $RHO = 0.71$ $p = <0.001$.

These findings indicate that, although statistically significant between Care Groups, the Section Three and Four scores were the least variable and that these organisational characteristics were relatively stable features of the climates experienced by these nurses. The scores from the remaining three sections; Introduction of New Ideas and Innovation; Effective Organisation of Nursing Activity, and Standards of Nursing Care, were both significantly different between Sectors and Care Groups and significantly correlated with care scores. The organisational issues addressed in these sections were therefore the most important in terms of understanding variations in the observed standard of nursing care.

The significantly higher climate scores of nurses based in Sector Four suggest that these nurses had considerable advantages compared with their colleagues in the other Sectors, and that these were subsequently reflected in their significantly better standards of nursing care. Sector Four nurses also enjoyed other advantages such as; the GEPAS information system, the greater number of depot drug settings, and smaller depot drug setting caseloads.

CHAPTER EIGHT

Discussion, Conclusions and Recommendations

Caring for schizophrenic patients in the community has recently come to wide public attention as a consequence of concern regarding offending by patients. This has led to the government recommending improved and more effective supervision of discharged patients. The need to administer depot drugs can provide an important opportunity for this supervision to occur. The findings in this study suggest that more effective use could be made of these regularly occurring contacts.

The concept of organisation climate proved useful in terms of both describing the organisational environments experienced by CPNs and in exploring differences in the standards of nursing care observed. The significant associations found between care and climate scores confirm that some organisational characteristics under which these CPNs worked had implications for the standard of nursing care they provided to patients.

Common themes to emerge were; an absence of managerial involvement in clinical activity, the lack of receptiveness to new ideas, policies and procedures that did not meaningfully address clinical practice, the ineffectiveness of some communication and decision making procedures, that the roles of responsibilities of CPNs were inaccurately defined, and that expected standards of nursing care were rarely stated and never monitored. Where nurses reported that these organisational characteristics were most deficient the standard of nursing care observed was significantly poorer.
It is therefore possible to reflect on both the nature of the organisational characteristics that nurses experienced and the

extent to which these either supported or detracted from the attainment of high standards of nursing care. The practical aspects of existing depot drug administration also contain evidence that setting caseload size and the duration of contacts significantly influenced standards of nursing care. Recommendations for change will be made regarding both depot drug administration practices and arrangements and the organisational environments in which nurses deliver their care.

Summary of Main Study Findings

Standards of Nursing Care during Depot Drug Contacts

The findings show that during most depot drug contacts the nursing emphasis was primarily that of drug administration. Almost half (48.12%) of all the interventions observed involved the giving of injections, with a further 19.78 percent dealing with the monitoring of drug related concerns. Less than a quarter of the 1259 interventions observed were not concerned directly with drugs.

During contacts which obtained the lowest care scores drug administration was found to be the predominant concern, and was often the only activity observed. In Care Groups One and Two, CPNs were so concerned with giving injections that over 90 percent of all the interventions observed were of the injection category. In spite of this emphasis on drug administration nurses regularly failed to monitor compliance with oral drugs. The monitoring of drug side-effects was virtually absent as only four such interventions

were observed during the 111 Care Group One and Two contacts.

In contrast the 91 contacts allocated to Care Groups Three and Four showed an increased frequency of drug related and other care interventions, with the injection being only one part of a relatively comprehensive care package. During these contacts there was also an increase in other care interventions where needs such as sleep, diet, hygiene, and personal and social concerns were more often explored by CPNs. Care Group Four contacts were particularly noted for the greater number of interventions involving drug side-effects monitoring. These contacts attracted significantly higher care scores and involved significantly longer durations than did the mainly injection orientated contacts of Care Groups One and Two.

The failure of CPNs to regularly monitor drug side-effects, oral drug compliance, the physical and mental health of patients, or their social and personal concerns and circumstances were important omissions in their nursing practice. Almost half of the contacts involved patients who were receiving anti-parkinsonian drugs suggesting that drug side-effects were a recognised risk, or were already evident, in some patients.

The lack of information CPNs had regarding the oral drug regimes of some patients had a detrimental effect on their standards of care. They often failed to monitor compliance with oral drugs and, in some cases, may have been unaware that any oral drugs had been prescribed. However, CPNs themselves must accept some of the

responsibility for these omissions. They should have been aware many schizophrenic patients living in the community are being prescribed oral drugs and that compliance with these is important if deterioration of a patients condition is to be avoided.

The emphasis on drug administration was also apparent among patients, most of whom were knowledgeable regarding their drug regimes. The researcher gained the impression that some patients measured the success of their treatment mainly in terms of reducing drug dosages. During some contacts CPNs congratulated patients on reductions to their drug dosages, or gave encouragement to them to pursue this topic with their doctor. Patients appeared to view contact with a nurse as being secondary to their receiving a depot drug injection.

The overriding emphasis on injection giving, to the detriment of other nursing care activities, confirm that CPNs approached many contacts simply in terms of the requirement to administer a depot drug injection. There was a considerable variation in the standard of nursing care observed and this was most significant between the four managerial sectors. Both the practical aspects of depot drug injection arrangements, such as setting caseload size, and the organisational features according to the measurement of climate, were found to be significantly associated with standards of nursing care.

Arrangements for Depot Drug Administration

Although each of the sectors catered for a similar population size the variation in the number and type of settings used in each is notable. Sector Four contained more settings than any of the other sectors and these were mostly located in health centres. This variation in provision was not a direct consequence of meeting community mental health care needs but relates to arrangements to meet the general health care needs of the local population and the organisation of GP services.

The greater number of health centres in Sector Four resulted in a more localised service and patients were offered a choice of settings in which to receive their injection. This helped to integrate community psychiatric nursing care with mainstream health care provision. CPNs in Sector Four took full advantage of the greater number of health centre facilities whilst their colleagues in the remaining sectors were more dependent on CPN offices and hospital clinics.

The CPN office facilities were broadly similar throughout the main study area in that all were primarily Health Visitor and District Nursing bases. Undoubtedly the facilities of CPN offices were more limited than those in health centres but in utilising these settings CPNs were at least able to conduct clinics outwith hospitals. These settings also allowed some degree of integration with other health care services.

Medical staff were based in the two hospital clinic settings and regularly saw patients prior to their attending the nurse for injection. The minimal attention these nurses paid to drug related concerns, such as monitoring side-effects, may be a result of this practice in that they may have assumed that medical staff would monitor these concerns. Since not all patients were seen by medical staff prior to receiving their injection this failure to routinely monitoring drug related concerns represented an important omission in patient care. In both these settings there was minimal evidence of interventions unrelated to drug administration and the nursing care observed suggests an emphasis almost entirely based on the administration of injections.

A further concern regarding hospital clinics is that, unlike health centres and CPN offices, no integration with other aspects of health care services was involved. Patients had to regularly return to hospital for their injections which could be seen as inappropriate where there existed a CPN service to support patients in the community. One of the hospital clinic CPNs commented that some CPNs in the sector concerned were reluctant to administer injections since they considered this to be a low priority task.

Within the three sectors containing the two grades nurses based in CPN departments the standard of nursing care was not significantly different between those who held post-basic qualification and those who did not and any benefits arising from post-basic training were not evident in the standards of nursing care observed. The findings reveal that CPNs within each sector tended to exhibit a similar

standard of care irrespective of whether or not they had held post-basic training. As such it seems that local factors, such as setting caseload size, negated any advantages that post-basic training might bring. This is supported by the fact that CPNs without post-basic training in Sector Four achieved a higher standard of care than those with this qualification in the other sectors, confirming that conditions in Sector Four were more conducive to attaining better standards of nursing care.

The subject of setting caseload size proved to be relevant in terms of standards of nursing care. In the larger caseload settings CPNs were required to give more injections during each session and contacts in these were significantly briefer, and care scores significantly lower, than those observed in lower caseload settings. CPNs also reported that it had proved impossible to persuade some patients to attend at specific times and queuing was common at the beginning and end of sessions, particularly in the higher caseload settings where a queue of seven or eight patients awaiting injection was at times observed by the researcher.

Apart from the prescription documentation, which was standard throughout the study area, the most common record used were the diaries in which the names of patients due to attend on a particular date were listed. Most CPNs also used the diary to record the site where the injection had been given and to note the date of the next appointment, along with the injection site to be used then. Most patients were also given appointment cards into which CPNs would enter the date of their next attendance. While some CPNs did admit

to having care plans these were not routinely brought to depot drug sessions, although some CPNs did maintain written notes in a kardex type format. At that time no standard form of care plan was in use but nursing management were planning to introduce one.

CPNs reported that oral drug prescribing, especially where GPs were involved, posed a major communication problem. Depot drugs were provided for CPNs conducting clinics by the parent hospital pharmacy, and were used for both Consultant and GP referrals. Oral drugs were not routinely provided by hospital pharmacies apart from a temporary supply given to patients on their discharge from hospital and most were prescribed by GPs who, according to the CPNs, did not always inform them of the prescription details.

There may be administrative or cost reasons which have led to the separation of depot and oral drug prescribing. The findings suggest that this practice did have implications for standards of nursing care and led to CPNs failing to monitor compliance with oral drugs, possibly because they were often unaware that they had been prescribed.

An unique record was the computerised information system, known as GEPAS, and which was only used in Sector Four. This required nursing staff to monitor and record drug side-effects. During observation CPNs received additional care scores when they displayed evidence of side-effects monitoring so that the requirements of the GEPAS system did make a contribution to the significantly better care scores in Sector Four. It should be noted that GEPAS was mainly

directed towards drug related concerns and did not address other mental health care needs. The nursing monitoring of drug side-effects was so obviously associated with GEPAS that these interventions were rarely observed outside Sector Four. Indeed, CPNs in Sector Four who were observed monitoring drug side-effects for the GEPAS record did not always carry out these same monitoring techniques when dealing patients for whom the GEPAS system did not apply.

Organisational Characteristics Experienced by CPNs

That the only significant difference in the climate scores of individual CPNs occurred between the four sectors strongly suggests that each can be viewed as separate organisation, with each having it's own 'mix' of characteristics. This was accompanied by variations in the facilities and arrangements for depot drug administration and by significant differences in the standards of nursing care observed across the sectors.

A climate facilitating the introduction of new ideas and innovation was most evident in Sector Four. While most CPNs agreed that new ideas were frequently suggested only those in Sector Four said that any new ideas that were suggested might subsequently be implemented. A frequently cited constraint was the role of managers, who some the CPNs felt did not encourage or support change, and especially so when there were resource implications. CPNs suggested that their managers, because of a lack of familiarity with clinical practice, did not always fully appreciate the possible advantages of new ideas

suggested to them. However, some CPNs also indicated that they were not particularly enthusiastic about managers having a closer involvement with their clinical activities.

That the climate for innovation was most evident in Sector Four and may be partly a consequence of the different arrangements for depot drug administration in this sector. The greater number of settings involved, and significantly smaller setting caseloads, reduced the demand to simply give injections and allowed these CPNs greater flexibility in their dealings with patients, which was reflected in the significantly better standard of nursing care observed in this sector.

Although the Sector Four CPNs echoed the view that their managers were not closely involved in day-to-day clinical matters they did report that their managers were reasonably responsive to their suggestions, had an interest in clinical matters, and would offer support and encouragement. Sector Four CPNs, unlike those in other sectors, appeared less inclined to interpret managerial support as representing undue interference in their activities.

The GEPAS system, which was unique to Sector Four, is perhaps the most notable example of innovative practice. Although developed by medical staff the effectiveness of this system largely depended on the commitment of nursing staff. The CPNs in Sector Four were clearly enthusiastic regarding GEPAS and were prepared to thoroughly conduct the side-effects monitoring procedures required. They were also well aware that the monitoring they carried out was not being repeated by their colleagues in the other sectors.

CPNs revealed that few of the formal policies and procedures dealt with nursing practice, and were mainly concerned with administrative or managerial issues. They reported that they participated in most decisions affecting their daily activities. However, the majority of these concerned their clinical activities and these were rarely the subject of formal policies and procedures. This does not imply a willingness amongst managers to allow CPNs to fully participate in decision making but reflects that managers did not usually participate in clinical decisions. Some CPNs commented that they had a lesser involvement in managerial decisions, and particularly those where resources were involved.

Most CPNs noted that the formal description of their roles and responsibilities in job descriptions were largely inaccurate, and in some cases did not even encompass the fact that they were part of a community psychiatric service. Their descriptions of their role were not significantly different between sectors. All but one nurse reported that they did not take instructions exclusively from their nurse manager, again reflecting the comparatively minor role played by managers in clinical matters. A consequence of this was that the CPNs tended to develop closer links with the medical staff they regularly consulted with regarding clinical matters.

CPNs also indicated that they did not feel the various demands made on them were incompatible with how they saw their role. This appeared to be mainly because they were not restrictive regarding what activities they considered appropriate for their involvement. The most commonly expressed concern was of the volume of work rather than what was entailed in terms of nursing activity. They again

noted that they had authority to define their own priorities and these were mainly related to the clinical activities which formed the bulk of their work. They felt able to comply with managerially defined roles by adhering to administrative procedures while, at the same time, they were relatively unconstrained by policies relating to the clinical activities that formed the bulk of their work.

CPNs expressed concern that they did not possess all the skills required to fully respond to every demand made of them. They cited needs such as family counselling, behaviour modification and alcohol abuse as being clinical challenges they regularly faced but often felt unprepared for. This may be a further illustration of the problem of managers, who controlled the training resources, having little direct clinical involvement. They may have been unaware of the full range of activities that some CPNs were involved with and, therefore, had limited scope either to identify these additional training needs or to sanction the activities involved. The reluctance of some CPNs to encourage closer managerial participation perpetuated their concerns yet also served to deprive them of managerial support to resolve the issue. It appears that some may have preferred to cope with existing difficulties rather than involve their managers more closely.

With regard to working relationships these were reported as being stable. Most CPNs described a generally supportive environment, particularly regarding relationships with their peers. The only comments of note here regarded how they viewed their managers. Some CPNs noted that managers only became involved when a mistake

occurred and that the reason for doing so was administrative and to apportion blame.

The climate findings show that an emphasis by the organisation on standards of care was not a prominent feature in the climates experienced by CPNs. This may be the most obvious consequence of the lack of managerial participation in clinical matters. Since few formal policies and procedures dealt with clinical practice these were largely left to the discretion of individual CPNs. Where there was a clear managerial involvement with standards of nursing care, such as in the proposed introduction of a standardised care plan format, some CPNs appeared to doubt both the motives of their managers and even the relevance of their contribution.

While most reported that standards of nursing care were regularly discussed they were also sceptical regarding how relevant this topic was. Some felt that the current focus on standards was fashionable and was largely a consequence of both a managerial ethos and the current consumer orientated perspective of health care. Others expressed the view that defining standards of care was not an essential element of delivering an acceptable standard of care, since CPNs would always seek to attain high standards without these having been defined for them elsewhere.

Of particular concern is that all 17 CPNs described no established monitoring of standards of nursing care. Even where some standards had been defined and introduced the absence of any monitoring arrangements did not permit confirmation as to whether or not these

were being regularly attained. In addition, there was no opportunity to assess whether any standards that had been defined were appropriate before CPNs were expected to comply with them.

A view existed which implied that standards of care were constrained by the lack of resources, although not all CPNs indicated that more nursing staff were required. A number cited issues such as a lack of support services, particularly secretarial support, and the demands of their own administrative duties as factors which reduced the time they could spend with patients. The CPNs in the higher caseload settings also commented on the lack of time they had available to spend with patients during depot clinic sessions.

Organisational Characteristics and Standards of Nursing Care

The most obvious confirmation of the relationship between standards of care and climate are the statistically significant associations between these factors. Significant positive correlations were found between climate and care scores for three of the five sections of the instrument and the climate scores for all sections were significantly different between care groups.

Scores from the section of the instrument dealing with innovation were significantly correlated with care scores, and were also significantly different between care groups. These findings confirm that observed standards of nursing care were significantly better where CPNs felt a greater ability to innovate. This was was minimal in Sectors Two and Three, was apparent to some extent in Sector One,

but was most evident in Sector Four where the observed standards of nursing care were significantly better.

Climate scores regarding aspects of organisation structure were significantly correlated with care scores and were significantly different between care groups. Sectors One and Four had the most effective structures in terms of communications, information, and decision making. These features supported the significantly better standards of care observed during contacts in these sectors.

Climate scores arising from the standards of nursing care items were also significantly different between care groups and were significantly correlated with care scores. The findings show that the organisational characteristics associated with higher standards of nursing care were most apparent in Sector Four, where the observed standards of care were significantly better. Standards of care were discussed in all sectors but only the CPNs in Sector Four reported that some attempts to implement standards had begun. A major concern was the absence of formal monitoring arrangements in all sectors. It was also apparent that some CPNs were not enthused by this topic and saw standards of care as being mainly a preoccupation of management.

Climate scores from the section addressing nursing roles did not result in a significant correlation with the observed standards of care, although these scores were significantly different between care groups. This absence of a significant correlation with care scores suggests that defined roles were of limited importance in

terms of the variations in the standards of clinical practice observed.

Most CPNs reported that their job descriptions did not accurately reflect their clinical activities. To some extent this finding is surprising in that matters related to role, such as in the job descriptions of CPNs, are areas where managerial involvement might be expected. However, this is consistent with the overall lack of managerial participation in clinical matters described by these CPNs.

Working relationships, addressed in section four of the instrument, were also of limited relevance in terms of standards of nursing care. Although significant between care groups, no correlation with care scores was found. Nurses reported similar levels of warmth and support and that working relationships were good, particularly with their peers. However, some CPNs were clearly uneasy at the prospect of managers becoming more closely involved with clinical activities.

Implications for Theory

Organisational Climate

To some extent this utilisation of climate differs from much of that previously reported in the literature. Researchers have most often used factor analysis to determine what number and type of dimensions had been measured by the instrument. The studies of Sims and Lafollette(1975) and Muchinsky(1976), both using the same Litwin and

Singer(1968) instrument, are examples of this approach. Even when applying the same original instrument these two studies did not derive identical dimensions of climate.

The views of Schneider(1975), who suggested that climate was primarily determined by the practices and procedures of organisations, can account for such findings in that different dimensions of climate may apply in different organisational situations. This was also the view of Muchinsky(1976), who advised that when formulating dimensions of climate the nature and purpose of the organisation being studied should be taken into account.

In this study dimensions of climate were formulated using characteristics described in the organisation theory literature, and which were appropriate to a nursing situation. There is clearly scope for climate to encompass other characteristics in addition to those explored in this study. For example, a different range of dimensions to those used in this study may be required when exploring hospital based services. Or, as Schnieder(1975) suggested, climates may be explored from the perspective of a particular issue, such as components which best support innovation.

The debate regarding whether climate was a descriptive or an affective concept was also discussed earlier. That climate is primarily a descriptive concept was accepted but, in view of this debate, the climate instrument was constructed to allow respondents to make both a descriptive and affective response to each item. The findings show that while there were significant differences between

the descriptive climate scores there were no accompanying significant differences in affective scores.

As a result it can be concluded that the personal views of CPNs were similar regarding the organisational issues explored in the instrument, and did not significantly vary even when the descriptive scores indicated significant differences in the organisational features of their working environments. This suggests that the affective views of these CPNs were obtained independently from their description of their immediate organisational environment. As such the descriptive scores can be viewed as being a representation of the organisation rather than the personal views of these CPNs.

In Chapter Three it was proposed that, using the model proposed by Donabedian(1966) for the evaluation of health care, researchers had paid insufficient attention to the structural factors that have the potential to influence the processes involved in delivering nursing care. Where these have been addressed the tendency has been to concentrate on factors such as the numbers of CPNs and patients (Harrigan et al 1993). Organisational characteristics, which Bloch(1975) identified as being an element of structure, and which in this study were significantly associated with variations in nursing practice, have largely been ignored as a focus for nursing research.

That the nature of the organisation is revealed from the perspective of its individual members is a particularly useful feature of climate. These findings have shown that most formally defined

aspects of the organisation, such as job descriptions and policies, do not fully reflect the activities of its CPNs. As such if this organisation were to be studied without taking into account the experiences of its CPNs then any conclusions regarding the nursing support provided to mentally ill patients living in the community may be misleading.

Some of the organisational deficiencies encountered by these nurses, such as the lack of continuity between them and their managers, and high setting caseloads, clearly did not enhance the attainment of high standards of care. Other organisational features, such as encouraging innovation, did support and encourage better standards of nursing care. It is notable that within this service measuring climate revealed that the organisational characteristics influencing its CPNs were variable, particularly so between the four managerial sectors.

The preceding findings and discussion have concentrated on the various organisational characteristics using the dimensions of climate defined for this study. These findings can also be considered in terms of the organisational concepts discussed in the Chapter Three.

Nursing and Organisational Goals

To some extent interventions regarding the monitoring of drug side-effects and compliance with oral medicines do represent specific goals. However, these occurred mainly as the result of CPNs

complying with the demands of the GEPAS system in Sector Four, and were rarely a feature during contacts in this sector where GEPAS did not apply and were virtually absent in the other sectors.

The absence of consistent forms of nursing records, such as care plans, in which the wider aspects of nursing care might be addressed is a further illustration of the lack of nursing goals other than those involving drug administration. The predominant nursing goal encountered during most of the observed contacts was simply to give a depot drug injection. There was minimal evidence of nursing goals unrelated to drug administration occurring with any regularity.

Two themes encountered throughout the climate findings were the absence of managerial involvement in clinical activities and that formal policies and procedures did not address clinical matters. As a result it appears that there were few formal organisational goals dealing specifically with clinical nursing practice. This is further supported by the climate findings which confirm that standards of care were largely undefined and that no monitoring of the care given was being carried out.

The difference between formal and real goals(Etzioni 1964) is apparent in these findings. Since formal organisational goals for nursing practice were largely absent the real goals of CPNs, which were more clinically orientated, were more prominent. However, since the activities that CPNs cited as being their real goals were not managerially coordinated or sanctioned then these were not also expressed as formal organisational goals for nursing. As such the

resources, such as additional training and facilities, that CPNs felt they required had not been provided. The reluctance of many of these CPNs to more closely involve their managers in clinical matters did not contribute to resolution of their concerns.

Nursing Roles

Prescriptions of the roles of CPNs have acknowledged their distinct role in drug administration and management. Some have cited this as being an important factor in the comparatively recent emergence of CPN services. However, the CPNs role in drug administration extends beyond that of simply giving medicines. Barker(1981) suggested that this extends to a role in monitoring the effectiveness of medicines. Researchers have also described other roles for CPNs unrelated to drug administration and management. For example, Carr et al(1980) identified six components of the CPN role.

From these findings it must also be concluded that these other roles were not evident during most of the observed contacts, since the emphasis was firmly on injection giving. The variability of service arrangements and climates within the study area also contributed to CPNs tending to adopt roles more in response to local conditions rather than as a means of ensuring that they provided a comprehensive package of nursing care for patients.

It might be argued that for depot receiving patients there may be other opportunities which would permit CPNs to enact these wider roles. To use the depot drug contact solely to give an injection is

wasteful of an opportunity which, if used more constructively, might result in fewer additional contacts. Alternatively, where further contacts are indicated, the nursing actions needed then might be planned more carefully. That CPNs might deliberately not assess or explore key issues during every contact with patients does not represent good nursing practice and does not concur with the various components of the role prescribed for CPNs.

CPNs also viewed the formal definitions of their role as deficient in that expected standards of care were inappropriately addressed in their job descriptions. Their main concern was the number of demands made of them rather than what range of activities these demands entailed. Their reluctance to involve their managers more closely with their activities again deprived them of an obvious means of addressing and resolving this problem.

Organisational Structure

Within organisational theory literature the term organisational structure encompasses the important functions of allocating and coordinating activities, along with any related policies and procedures. The findings of this study strongly suggest that the formal structure of the services studied did not address or support the nursing activities of its CPNs.

Georgopoulos(1972) noted that it may be difficult to fully reflect the activities related to health care provision within the formal structure of an organisation. However, in the case of this

organisation, it appears that the formal structure was largely devoid of any formal policies or procedures dealing with standards of nursing care. CPNs were able to comply with most that had been defined, and could do so without excessive intrusion into their clinical activities. They also complained that some of the information they required, particularly managerial information, was either inadequate or unavailable. Clinical information was less problematic, possibly because the formal structure was less involved with this type of information.

CPNs noted that managerial involvement was most apparent where resources were involved. As such it appears incongruent that the clinical activities of CPNs were not a prominent feature of structural arrangements, since staff salary costs would account for the largest single resource under the control of managers. The level of resources committed to those issues which the CPNs indicated that managers were most concerned with, such as training monies and introducing the standardised Care Plan, would be minimal compared with staff salary costs.

According to the affective scores in the climate instrument, CPNs approved of the range of organisational practices and procedures they were asked to describe. Their responses show that they supported innovation, clearly defined and meaningful roles, effective communication and decision making, and the definition and monitoring of care standards. In their descriptions of their working environments they reveal that the organisational characteristics under which they worked fell short of their preferences.

The findings therefore suggest that many of the organisational characteristics experienced by these CPNs did not enhance or support nursing practice. The nature of these characteristics was variable, particularly between sectors, where differences in climate significantly associated with variations in standards of care. The two main issues which emerged were that clinical activities were not accurately or formally reflected in organisational arrangements, so that these had limited relevance for CPNs or the care they provided for patients. This was exacerbated by the lack of managerial participation in nursing practice and care delivery.

Duration of Contacts

The findings revealed a highly significant relationship between the observed standard of care and the duration of contacts. In effect, the shorter the contact the lower the standard of nursing care observed. Two scenarios can be suggested to account for this finding. Poorer standards of care and briefer contacts were the result of CPNs having a limited amount of time to spend with each patient or, alternatively, occurred simply because CPNs planned to do little more than administer depot drug injections.

It is compelling to suggest that CPNs should simply allow for longer contacts with patients and that, as a consequence, their standards of nursing care would improve. However, such an assertion is not wholly supported by these findings. The significant differences and associations between climate and care scores indicate that the variable standards of care observed were also accompanied by the

significant differences in climate reported by these CPNs. As such, the wider organisational issues measured using climate are equally important so that simply allowing for longer contacts would not necessarily be sufficient to improve standards of nursing care.

While CPNs may have desired longer contacts those based in the larger caseload settings were probably unable to directly reduce the number of patients attending so as to facilitate this. The practice of medical staff directly referring depot drug patients to CPNs, the extent of depot drug prescribing, the limited number of settings outwith Sector Four, and the lack of nursing managerial involvement in clinical matters, all contributed to this situation. That some CPNs were reluctant to more closely involve their managers reduced the likelihood of any improvement, since managers may have been unaware of the level of demand for depot drug administration.

The brief duration of contacts appears then to be mainly a consequence of organisational practices and procedures surrounding depot drug administration rather than the preferences of CPNs themselves. It is likely that the duration of contacts could only be increased by a review of, and subsequent changes to, existing arrangements. Of particular concern are the referral procedures for depot drug clinic attendance and the locations and numbers of clinics required to meet local needs. A closer relationship between CPNs and their managers and a greater appreciation of the problems of demand by prescribing medical staff would be beneficial.

Meeting the Needs of Patients

It is impossible to state whether or not the services studied fully met the needs of the patients during depot drug contacts since the information available to the researcher did not indicate that these needs had been defined in terms other than drug regimes. However, assuming that the needs of these patients are more complex than just drug administration, and in view of the emphasis on injection giving, it is unlikely that their needs were being comprehensively assessed.

Continuity of care was compromised by the practice of CPNs conducting clinics giving injections to patients on the caseloads of their colleagues, where the responsibility for the care of these patients was vested in the other nurse. The reasons for this practice appear to be based on the assumption that depot drug injections can be divorced from the overall care of patients, and that it is more efficient to centralise injection giving. While the standard of care during these contacts was not significantly different from those where the patient was part of the caseload of the nurse concerned this practice does not facilitate effective continuity of care.

Furthermore, there may be a tendency in this situation for CPNs conducting the depot drug clinics to view certain patients as being primarily depot drug injection recipients, so that they may be more inclined adopt an injection giver role during these contacts. This is a particular concern in the higher caseload settings, in which

the emphasis on drug administration was most marked. Patients attending these settings and who were not the responsibility of the injecting nurse were even less likely to be assessed unless they presented with an urgent problem.

Some patient needs are directly attributable to their medication regime, particularly the monitoring of drug side-effects and oral drug compliance. The findings indicate that the routine monitoring of these needs was largely confined to Sector Four and that elsewhere these were erratically monitored. Since oral compliance was not monitored during 105 contacts where this would have been relevant the needs of patients are clearly not being fully met in this respect.

The problem of communication and prescribing practices described earlier was undoubtedly an important factor in the frequent failure of CPNs to monitor oral drug compliance. It appears reasonable to assume that CPNs would have an expectation that both drug side-effects and oral drug compliance would be common concerns when dealing with depot drug patients. In view of this, and given the potential long-term consequences of neuroleptic drugs for the well-being of patients, that CPNs consistently failed to meet these needs is of major concern.

From their comments it appears these CPNs did have the intention of addressing the needs of their patients beyond those relating to the maintenance of drug regimes. This contrasts dramatically with the nature and content of their observed care, since less than 25

percent of the interventions the carried out dealt with needs other than drug treatment.

It may be argued that concentrating on injections during contacts is efficient, at least in terms of the number of patients being injected, and that patients may be seen subsequently by CPNs to deal with their other needs. However, if these subsequent contacts did not occur, so that the depot drug injection represents the most regular contact some patients have with mental health care services, then it is essential to use these contacts effectively. The findings in this study demonstrate that many of these contacts were being ineffectively utilised.

The main thrust of new government proposals(HMSO 1993) is the introduction of supervised discharge and an extension to the period during which patients on leave from hospital can be recalled if necessary. Other issues addressed in these proposals include the publication of guidance to avoid the inappropriate discharge of patients into the community and ensuring that those who are discharged receive adequate support. A review, by the Clinical Standards Advisory Group, of appropriate care standards for schizophrenic patients in hospitals and in the community is promised.

Whilst this initiative mainly addresses the wider legal and policy implications surrounding the care of schizophrenic patients in the community, understandably in view of public concern regarding cases of offending, it is important to also recognise that an essential

aspect of effectively caring for these patients lies in their day-to-day concerns, problems, and achievements. It is these personal aspects which constitute quality of life for individual patients, and which practice and policy developments should seek to foster and improve upon.

An essential component of caring for patients in the community must be to ensure that all their contacts with health care agencies are used constructively. Whilst the demands of supervised discharge will apply to some, particularly those at risk of offending, many patients will not be subject to these controls but will still have major mental health and social care needs. An obvious opportunity to provide comprehensive and frequent monitoring for many schizophrenic patients occurs during their contacts with nurses to receive depot drug injections.

Implications for Practice

The findings clearly show that nursing practice during many of the observed depot drug contacts was characterised by a preoccupation with the administration of injections. The emphasis on injection giving was exacerbated by patients following the example of nurses and similarly approaching these contacts mainly as occasions to receive injections. The monitoring of both drug side-effects and compliance with oral medicines was irregular and the needs of the patients unrelated to drugs were infrequently assessed. The information used by CPNs during these contacts was largely drug related and care plans were not apparent during most of the observed contacts.

The range and quality of information used by CPNs is critical to the attainment of high standards of care. CPNs should participate in any reviews of information formats to ensure that these appropriately reflect both nursing practice and the needs of patients. The separation of oral and depot drug prescribing and the poor communication of prescription information between some GPs and CPNs are issues requiring urgent review. It may be that the consequences of these prescribing arrangements for the monitoring of oral drug compliance by CPNs has not yet been appreciated within the main study area.

The climate findings show that inadequacies in some organisational characteristics were significantly associated with the poorer standards of nursing care observed. The findings contain strong evidence that the formal organisational practices and procedures did not fully reflect the actual activities of CPNs or the needs of patients. This was exacerbated by the clear division between CPNs and their managers, where each group has its separate priorities and agenda. The apparent disparity between clinical nursing practice and managerial activity has not been fully recognised and the reluctance of some CPNs to encourage closer involvement served only to maintain this situation.

The variation in both depot drug administration arrangements and standards of nursing care illustrate the different approaches to these contacts adopted within the main study area. The care observed rarely encompassed the range of clinical roles suggested for CPNs and appeared to be influenced more by local factors such as the

organisational issues revealed in the climate findings. The potential value of depot drug contacts in providing an important and regularly occurring opportunity to effectively monitor and supervise schizophrenic patients living in the community was not generally recognised nor deliberately exploited.

The major implication for practice arising from this study is that these depot drug delivery arrangements should be reviewed and that there is scope for the standard of nursing care currently provided to be improved. The climate findings also show that organisational factors were significantly associated with standards of nursing care. However, it is unlikely that CPNs, by themselves, would have any great influence over these organisational issues. As such, a closer liaison between CPNs, their managers, and others involved in planning this service is critical to improving nursing practice within the main study area.

Limitations of the Study

The study focused on specific issues related to depot drug administration. Direct nursing care was explored during the depot drug injection contacts and the components of climate were formulated to address specific characteristics extracted from the organisational literature. As such, it is also worthwhile to consider both organisational climate and the implications for patient care in a wider context.

Organisational Climate

Organisational issues have not been a major feature of nursing research. Even where organisational approaches have been adopted by nursing researchers concepts other than climate tend to have been used, as two recent nursing studies illustrate.

Forrest(1992) studied the care given in two residential settings for the mentally ill, one a hospital ward and the other a social work hostel, with the aim of describing the 'life experience of participants [both residents and carers] in these settings' (p.1). She adapted the work of Moos and Lemke(1984) and used three quantitative measures. One of these addressed the physical features of residential care settings, such as safety features to minimise accidents. The second measured the policy and programme characteristics of the settings, with an emphasis on quality of care, and the third examined the subjective perceptions of carers and residents regarding their social environment.

The measurement of the physical characteristics of settings is of of limited interest here, since the present study involved patients who were living in their own homes. The policy and care programme measure had a clear perspective on the 'balance between individual freedom and institutional control' (p.41), and focused on the availability and appropriateness of services and facilities and the participation of residents.

The third measure, the Sheltered Care Environment Scale, was used to obtain the subjective perceptions of respondents regarding their social environment. Clearly, as the name suggests, this instrument is aimed at those whose environment is a residential setting. In organisational terms the main issues involved were the importance and relevance of rules and procedures, the degree of influence residents had on these, and the extent to which staff used these to direct residents.

Shaw(1990) used the concept of 'culture' to explore the care of elderly patients in geriatric long stay hospital wards and it's relationship with job satisfaction. A particular focus was the extent to which management practices were seen as being participative (open) by nursing staff, and whether the degree of 'openness' was associated with job satisfaction levels. This study involved 79 wards and a questionnaire was developed to measure nursing staff perceptions of openness. The scores from this instrument were then analysed along with those from an instrument used to measure job satisfaction

In contrast, climate offers an alternative perspective to the approaches adopted by both Forrest(1992) and Shaw(1990), who both placed a clear emphasis on the subjective views of the respondents. This is fundamentally different to climate, where the emphasis is expressly descriptive. The important differences between climate and the more subjective concept of job satisfaction were discussed in Chapter Three.

The use of climate in this study has provided a useful and topical view of a mental health care organisation, as these were described by nurses who were largely delivering their care outwith institutional settings. This has resulted in a different perspective on nursing care compared with the studies of Forrest(1992) and Shaw(1990), neither of whom explored the same range of organisational characteristics, and where the focus was on residential care settings as opposed to community psychiatric nursing services in the present study.

The problems of reliability and validity associated with some climate instruments, as discussed earlier, is an important issue. That a single climate instrument, with acceptable levels of reliability and validity, has not yet been developed is not surprising. As Schneider(1975) pointed out, every organisational situation will possess its climate. Given the diversity of organisational situations and working environments, and therefore climates, then reflecting all of these in a single climate instrument would perhaps be too ambitious.

However, this limitation must be set against the strengths inherent in the concept of organisational climate. Climate has the advantage of flexibility, where researchers have suggested that this extends to formulating components of climate which are appropriate to the situation to be studied. Furthermore, climate is descriptive in nature and can therefore provide alternative insights to those approaches more concerned with personal perceptions, such as job satisfaction.

In this study climate was used primarily as a means to comprehensively describe the organisational characteristics experienced by these nurses and to explore associations between these and the standards of nursing care observed. These aims were achieved. The findings revealed significant differences in climate scores, particularly between sectors, and also significant associations between climate and standards of nursing care. Furthermore, the descriptive information provided by nurses yielded meaningful insights into current mental health care arrangements within the study area. As such, these findings confirm that climate does indeed have merit as a basis for research into nursing practice and standards of nursing care.

There may, therefore, be benefits in using climate more extensively in future nursing research. Nursing has always been a profession with strong organisational links. The multi-specialist nature of nursing services, and the recent emergence of autonomous NHS Trusts, suggests that nurses will work in a variety of organisational situations. An awareness of the effects of the wide range of organisational characteristics that can have an impact on nursing practice is a valid research topic, and climate may provide a particularly useful means of exploring these.

While the climate questionnaire developed can be considered valid only for use in this study, a more frequent use of climate in nursing research may also allow climate dimensions which are particularly relevant to nursing to be determined. This, in turn, may eventually permit the development of a climate instrument which,

at least for nursing use, might have acceptable levels of reliability and validity.

Nursing Contribution to Patient Care

In this study the focus on depot drug administration contacts was deliberate. In previous research into community psychiatric nursing the depot drug contact was often cited as a key activity of CPNs but the nature and content of these contacts had not been explored in any detail, prompting this study. The findings obtained show that many depot drug contacts were brief, and that standards of nursing care were generally poor due to the emphasis on drug administration. Contacts where higher standards of care were observed were characterised by a more thorough monitoring of drug related issues, such as side-effects rather than interventions unrelated to drugs or drug administration.

In the context of patient care, an issue which was not addressed in this study (since the stated aim was to focus on depot drug contacts) was the role of the depot drug contact as a component of the overall care package provided for patients. It has been argued that the potential of depot drug contacts was not being fully exploited within the study area, and even if these contacts were being used more effectively it would still be of value to discover what other opportunities nurses had to care for these patients, and how these were being utilised.

On the basis of the findings obtained it would be of major concern if the depot drug contact proved to be the main source of the nursing contribution to the care of the patients. In view of the lack of evidence of a comprehensive range of nursing interventions, and the brevity of many of these contacts, the findings imply that the nursing care of some of these patients must be considered as inadequate.

One of the main objectives of government policy is to 'improve significantly the health and social functioning of mentally ill people'(HMSO 1994). As such, and particularly for those patients living in the community, the range of services and care they receive, and the coordination of effort between the various agencies involved, are key issues. However, a recent report(Mental Health Foundation 1994) has illustrated the current fragmentation of services for these patients.

This report highlighted several areas of concern. It was concluded that a comprehensive strategy for the care of the severely mentally ill was urgently required, since responsibility is currently diffused across the various agencies involved. For example, there is confusion between the roles and responsibilities of health care and social support agencies. The authors recommended that the prime minister initiate a policy whereby a single statement be produced in which the responsibilities of each of the various agencies concerned is clearly stated, so as to encourage more effective collaboration.

Other issues, such as the lack of resources and the consequences of constant organisational change, were also cited as factors constraining the delivery of services to seriously mentally ill patients living in the community. In this study instances of fragmented care delivery were also revealed. For example, the system of 'informal' depot drug contacts does not encourage continuity of nursing care, while the practice of separating depot and oral drug prescribing between GPs and Consultants had implications for the monitoring of drug compliance by nurses.

Since the importance of integrating of the various components of caring for patients living in the community has been recognised it appears desirable that this approach should be reflected in future nursing research. While it is of undoubted value to explore specific aspects of nursing care, such as the depot drug contacts in this study, a proper evaluation of the care provided is perhaps best made in the context of the contribution of particular contacts within patients overall package of care.

In addition to highlighting where particular components of a care package are inadequate or acceptable, such an approach would allow the aims and objectives of the various situations in which care can be delivered to be defined. For example, if depot drug contacts are to be used mainly to give injections then what other opportunities for nurses to deliver care should be provided, how should these be utilised, and would the resultant overall nursing involvement represent an acceptable nursing contribution to the care of that patient?

As such, the comparatively narrow focus on the depot drug contact is therefore a limitation, although this particular event merited specific research and significant findings emerged. Future researchers who choose to concentrate on a particular component of nursing care, and particularly the different situations in which nurses and patients interact, may gain a clearer perspective by evaluating these in the context the overall nursing care provision for patients.

Conclusions and Recommendations

There should be an enhanced recognition of the potential for care that the regular contacts between CPNs and patients resulting from depot drug prescribing can facilitate. Given this recognition, these regularly occurring depot drug contacts will become the mainstay in the care and supervision of many schizophrenic patients living in the community.

It has been proposed that CPNs hold a number of key roles and depot drug contacts may provide them with a frequent opportunity to enact these roles and make a effective contribution towards the care of some patients. However, the depot drug contact should always be viewed as a component of a package of care provided for patients. While depot drug contacts should be utilised effectively it should also be recognised that these contacts alone may not represent an adequate nursing involvement, as the standard of nursing care exhibited during many of the contacts observed in this study confirms.

Greater priority must therefore be given to depot drug clinics in the organisation of CPN services. It was reported that some CPNs preferred to avoid giving depot injections and viewed this as being a low priority task. The findings also show that they tended not to undertake comprehensive nursing assessments in the depot drug clinic situation and, instead, concentrated on drug administration. If depot drug contacts are viewed as being a key component in the care of patients living in the community, this requires that CPNs approach these contacts in a more constructive manner.

A structured approach to depot drug contacts would have some advantages, such as in ensuring that certain interventions such as drug side-effects monitoring and the desired components of the CPN role were attained. Even so, nurses would still require sufficient flexibility so as to respond to the needs of individual patients. To achieve this complimentary changes to existing depot drug administration arrangements would be required, such as setting caseload size, and a full review of the organisational issues raised in this study.

Therefore, it is strongly recommended that closer links between management and clinical practitioners are developed. Their joint aim should be to ensure that the organisation of services will facilitate the attainment of the high standards of nursing care so that needs of patients are being better met.

In summary the major recommendations resulting from this study are;

1) A greater awareness is required of the potential value of the depot drug contact in the care of schizophrenic patients living in the community as an opportunity to both comprehensively assess patients and deliver high standards of nursing care. However, these contacts should always be viewed as part of a package of care.

2) Standards of nursing care should be developed specifically for depot drug contacts so that certain care issues, such as drug side-effects monitoring, are not overlooked. These standards should encompass the wide range of patient needs and reflect the roles for CPNs proposed in the literature. For this to be meaningful CPNs themselves must be closely involved.

3) Local arrangements for depot drug administration must encourage high standards by ensuring that levels of demand on individual settings allow CPNs adequate time and facilities to conduct suitably thorough assessments. Existing documentation and communication procedures should be reviewed.

4) Organisational practices and procedures in the main study area should be reviewed so that those which are inefficient or inappropriate are amended or removed, and others developed where necessary. It is essential that these meaningfully address clinical nursing practice and the needs of patients.

5) Closer cooperation between CPNs, managers and service planners should be encouraged so that the concerns, aspirations, and efforts of each are shared with the aim of providing a high standard of care and supervision to patients living in the community.

As was discussed earlier, mental health care has undergone a substantial degree of change since the prominence of the custodial asylum. Just as the introduction of neuroleptic drugs in the 1950's and 1960's resulted in a marked improvement to the treatment of mental illness the recent emphasis on maintaining patients in their communities is an equally dramatic development. The pace of change towards a community based service has been rapid and, since this study began, it has been confirmed that two of the four major psychiatric hospitals within the main study area are to close.

When caring for of mentally ill patients in the community, and particularly those with a schizophrenic illness, monitoring and effective supervision are essential. CPNs will play an increasingly important role in this supervision as the emphasis on in-patient care reduces. Fully utilising all their contacts with patients is essential for continuity of care and is also cost-effective. Bearing in mind that contacts involving depot drugs are often mandatory, so that prescribed injections can be given, then both managers and nurses must ensure that they make the most effective use of them.

The scale of organisational change impacting upon psychiatric nursing, arising from both the move towards a more community based

mental health service and government health care reforms, has been considerable. This may result in an even greater diversity of organisational environments in which nurses work and deliver care. To date these have not been a major focus of nursing research so that the nature and effects of organisational characteristics have yet to be fully understood from a nursing perspective.

Climate, as has been demonstrated, can provide a useful means of investigating these issues and the concept is sufficiently flexible so as to allow a variety of organisational situations to be explored. In view of the significant relationship between climate and standards of nursing care found in this study further research into the organisational climates experienced by nurses is indicated.

REFERENCE LIST

Aldrich, H.E. (1979) Organisation and Environments. New Jersey: Prentice Hall.

Altschul, A.T. (1972) Patient-Nurse Interaction Patterns in Acute Psychiatric Wards. Edinburgh: Churchill Livingstone.

American Psychiatric Association. (1980) Diagnostic and Statistical Manual of Mental Disorders-3rd edition(DSM-III). Washington DC.

Bamrah, J.S., Freeman, H.H., Goldberg, D.P. (1991) Epidemiology of Schizophrenia in Salford, 1974 - 84. Changes in an Urban Community over Ten Years. British Journal of Psychiatry. 159, 802-810.

Banton, M. (1965) Roles:An introduction to the study of social relations. London: Tavistock Publications.

Barker, C. (1977) A community psychiatric nursing service. Nursing Times. 73(28), 1075-1079.

Barker, P. (1980) Behaviour Therapy in Psychiatric and Mental Handicap Nursing. Journal of Advanced Nursing. 5(1), 55-69.

Blau, P.M., Scott, W.R. (1963) Formal Organisations: A comparative approach. London: Routledge and Kegan Paul.

Bleuler, E. (1911) Dementia praecox or the group of schizophrenias. English translation by Zinkin, J. (1950). New York: International Universities Press.

Bloch, D. (1975) Evaluation of nursing care in terms of process and outcome: Issues in Research and Quality Assurance. Nursing Research. 24(4), 256-263.

Boettcher, E.G., Alderson, S.F. (1983) Psychotropic Medications and the Nursing Process. Journal of Psychosocial Nursing and Mental Health Services. 20(11), 12-16.

Bowers, L. (1993) Good Practice and Depot Clinics. Community Psychiatric Nursing Journal. 13(1), 18-20.

Bradley, D., Wilkie, R. (1974) The Concept of Organisation: An introduction to organisations. Glasgow: Blackie and Son.

Brooker, C. (1984) Some problems associated with the measurement of community psychiatric intervention. Journal of Advanced Nursing. 9, 165-174.

Brooker, C., White, E.(eds) (1993) Community Psychiatric Nursing: A research perspective Volume 2. London: Chapman and Hall.

Brown, G.W., Monk, E.M., Carstairs, G.M., Wing, J.K. (1962) Influence of family life on the course of schizophrenic illness. British Journal of Preventative Social Medicine. 16, 55-68.

Brown, G.W., Birley, J.L.T., Wing, J.K. (1972) Influence of family life on the course of schizophrenic disorders: a relication. British Journal of Pyschiatry. 121, 241-258.

Burns, T., Stalker, G.M. (1961) The Management of Innovation. London: Tavistock Publications.

Campbell, J.P., Dunnette, M.D., Lawler, E.E.,III, Weick, K.E.,Jnr (1970) Managerial behavior, performance and effectiveness. New York: McGraw Hill.

Caplow, T. (1964) Principles of Organisation. New York: Harcourt Brau.

Carr, P.J., Butterworth, C.A., Hodges, B.E. (1980) Community Psychiatric Nursing: caring for the mentally ill and handicapped in the community. London: Churchill Livingstone.

Cheadle, A.J., Freeman, H.L., Korer, J. (1978) Chronic Schizophrenic patients in the Community. British Journal of Psychiatry. 132, 221-227.

Child, J. (1980) The contribution of organisation structures. In Lockett, M., Spear, R.(eds) Organisations as Systems. Milton Keynes: The Open University Press.

Clark, A.F., Holden, N.L. (1987) The Persistence of Prescribinh Habits: a Survey and Follow-up of Prescribing in Chronic Hospital In-patients. British Journal of Psychiatry. 150, 88-91.

Clegg, S., Dunkerly, D. (1980) Organsisation, Class and Control. London: Routledge and Kegan Paul.

Cope, D.E. (1981) Organisation development and action research in hospitals. Aldershot: Gower Press.

Cope, D.E. (1984) Changing health care organisations. In Skevington, S. Understanding Nurses. London: John Wiley and Sons.

Cormack, D. (1976) Psychiatric Nursing Observed: A Descriptive Study of the Work of the Charge Nurse in Acute Admission Wards. London: Royal College of Nursing.

Cormack, D. (1980) Psychiatric Nursing Described. Edinburgh: Churchill Livingstone.

Davidhizer, R.R., Austin, J.K., McBride, A.B. (1986) Attitudes of patients with schizophrenia toward taking medication. Research in Nursing and Health. 9(2), 139-146.

Dieterly, D.L., Schnieder, B. (1974) The Effect of Organizational Environment on Perceived Power and Climate: A Laboratory Study. Organizational Behavior and Human Performance. 11, 316-337.

Donabedian, A. (1966) Evaluating the quality of medical care. The Millbank Memorial Fund Quarterly. 44(3), part 2:166-206.

Donabedian, A. (1973) Aspects of Medical Care Administration: specifying requirements for health care. Cambridge: Harvard University Press.

Drexler, J.A. (1977) Organisational Climate: Its homogeneity within organisation. Journal of Applied Psychology. 62(1), 38-42.

Eberhard, G., Hellbom, E. (1986) Haloperidol Decanoate and Flupenthixol Decanoate in Schizophrenia. Acta Psychiatrica Scandinavica. 74, 255-262.

Etzioni, A. (1961) A Comparative Analysis of Complex Organisations. New York: Free Press of Glencoe.

Etzioni, A. (1964) Modern Organisations. New Jersey: Prentice Hall.

Etzioni, A. (1965) The semi-professions and their organisations. New York: Free Press. teachers

Ferguson, K.E. (1993) A study to inverstigate the views of patients and their carers on the work undertaken by nurses to prepare the patient for discharge from hospital. In Brooker, C., White, E.(eds) Community Psychiatric Nursing: A research perspective Volume 2. London: Chapman and Hall.

Forehand, G.A., Gilmer, B.V.H. (1964) Environmental variation in studies of organisational behavious. Psychological Bulletin. 62, 361-382.

Forrest, S. (1992) Hospital and Community Clients' and Carers' Experience of Life in two Residential Settings for the Mentally Ill. M.Phil. Thesis. University of Edinburgh

Freeman, H., Alpert, M. (1986) Prevelance of Schizophrenia in an Urban Population. British Journal of Psychiatry, 149, 603-611.

Friedlander, F., Margulies, N. (1969) Multiple impacts of organizational climate and individual value system upon job satisfaction. Personnel Psychology. 22, 171-183.

Gavin, J.F. (1975) Organisational climate as a function of personnel and organisational variables. Journal of Applied Psychology. 60, 135-139.

Georgopoulos, B.S. (1972) Organisation Research on Health Institutions. University of Michigan: Institute of Social Research.

Gold, R.L. (1958) Roles in Sociological Field Observation. Social Forces. 30, 217-223.

Goldberg, D.P. (1988) Further Observations of the Practice of Community Care in Salford. Differences between Community Psychiatric Nurses and Mental Health Social Workers. Britisj Journal of Psychiatry. 153, 30-37.

Gouldner, A.W. (1959) Organizational Analysis. In Merton, R.K., Broom, L., Cottrell, L.s.(eds) Sociology Today: Problems and Prospects. New York: Basic Books.

Greene, J. (1968) The psychiatric nurse in the community nursing service. International Journal of Nursing Studies. 5, 175-184.

Griffith, J.H., Mangen, S.P. (1980) Community Psychiatric Nursing: a Literature Review. International Journal of Nursing Studies. 17, 197-210.

Gross, W., Mason, W.S., McEarchern, A.W. (1958) Exploration in Role Analysis: Stidies of the School Superintendent Role. London: John Wiley and Son.

Gross, E. (1969) The defintion of organisational goals. British Journal of Sociology. 20(3), 272-294.

H.M.S.O. (1993) Community Supervision Orders. Government response to the fifth report from the health committee, session 1992-93. London.

Hall, R.H. (1980) Organisational Goals. In Lockett, M., Spear, R. (eds) Organisations as Systems. Milton Keynes: The Open University Press.

Hall, R.H., Haas, J.E., Johnson, N.J. (1967) An evaluation of the Blau-Scott and Etzioni typologies. Administration Science Quarterly. 12, 118-139.

Harrigan. P., Sorensen, J., Ryder, S. (1993) Clinical audit and CPN services. In Brooker, C., White, E.(eds) Community Psychiatric Nursing: A research perspective Volume 2. London: Chapman and Hall.

Haynes, R.B. (1979) Introduction in Haynes, R.B., Taylor, D.W., Sackett, D.L. Compliance in Health Care. London: The Johns Hopkins University Press.

HMSO (1994) Better Off in the Community? The care of people who are seriously mentally ill.

Holloway, F. (1988) Prescribing for the Long-term Mentally Ill: a Study of Treatment Practices. British Journal of Psychiatry. 152, 511-515.

House, R.J., Rizzo, J.R. (1972) Role conflict and ambiguity as critical variables in a model of organizational behaviour. Organization Behavior and HUman Performance. 7, 467-505.

Hunter, P. (1978) Schizophrenia and Community Psychiatric Nursing. Surbiton: National Schizophrenia Fellowship.

Hunter, P. (1980) Social Work and Community Psychiatric Nursing. A Review. International Journal of Nursing Studies. 17, 131-139.

Irons, P.D. (1978) Psychotropic Drugs and Nursing Intervention. New York: McGraw Hill.

James, L.R., Jones, A.P. (1974) Organisational Climate: a review of theory and research. Psychological Bulletin. 81, 1096-1112.

James, L.R., Jones, A.P. (1976) Organizational Structure: A Review of Structural Dimensions and Their Conceptual Relationships with Individual Attitudes and Behavior. Organisational Behavior and Human Performance. 16, 74-113.

Jessor, R., Jessor, S.L. (1973) The poerceived environment in behavioral science. American Behavioral Scientist. 16, 801-828.

Johannesson, R.E. (17973) Some Problems in the Measurement of Organizational Climate. Organizational Behavior and Human Performance. 10, 118-144.

Johnson, D.A.W., Wright, N.F. (1990) Drug Prescribing for Schizophrenic Out-Patients on Depot Injections: Repeat Surveys over 18 years. British Journal of Psychiatry. 156, 827-834.

Jones, A.P., James, L.R. (1979) Psychological Climate: Dimensions and Relationships of Individual and Aggregated Work Environment Perceptions. Organizational Behavior and Human Performance. 23, (201-250).

Katz, D., Kahn, R.L. (1966 and 1978(2nd edition)) The Social Psychology of Organisations. New York: John Wiley & Sons.

Kendell, R.E (1983) Schizophrenia. In Kendall, R.E., Zealley, A.K (eds) Companion to Psychiatric Studies - 3rd Edition. Edinburgh: Churchill Livingston. 275-296.

Krauss, J.B. (1980) The Chronic Psychotic Patient in the Community: A Model of Care. Nursing Outlook. May, 308-314.

Lawler, E.E., Hall, D.T., OLdhan, G.R. (1974) Organizational Climate: Relationship to Structure, Process and Performance. Organizational Behavior and Human Performance. 11, 139-155.

Leff, J.P., Wing, J.K. (1971) Trial of Maintenance Therapy in Schizophrenia. British Medical Journal, 3, 559-604.

Leff, J.P., Kuipers, L., Berkowitz, R, Eberlein-Vries, R., Sturgeon, D. (982) A controlled trial of social intervention in the families of schizophrenic patients. British Journal of Psychiatry. 141, 121-134.

Litwin, G., Stringer, R. (1968) Motivation and Organizational Climate. Cambridge: Harvard University Press.

McCreadie, R.G, Robinson, A.D., Wilson, A.O.A. (1984) The Scottish survey of chronic day patients. British Journal of Psychaitry. 145, 626-630.

Mental Health Foundation. (1994) Creating Community Care. Report of the Mental Health Foundation into Community Care for People with Severe Memtal Illness. London: Mental Health Foundation.

Merton, R.K. (1957) The Role Set: Problems in Sociology Theory. British Journal of Sociology. 8, 106-120.

Moos, R.H, Lemke, S. (1984) The Multi Phase Environmental Assessment Procedure: Manual. Stanford University, Social Ecology Lab. Palo Alto. California.

Muchinsky, P.M. (1976) An Assessment of the Litwing and Singer Organization Climate Instrument: An Empirical and Theoretical Extension of the Sims and Lafollette Study. Personnel Psychology. 29, 371-392.

Mullins, L.J. (1985) Management and Organisational Behaviour. London: Pimane Publishing.

Munton, R. (1990) Client satisfaction with community psychiatric nursing. In Brooker, C.(ed) Community Psychiatric Nursing: A research perspective Volume 1. London: Chapman and Hall.

Naylor, J.C., Pritchard, R.P., Ilgen, D.R. (1980) A Theory of Behaviour in Organsiations. London: Academic Press.

Parsons, T. (1960) Structure and process in modern societies. New York: Free Press.

Pasamanick, B., Scarpitti, F.R., Lefton, M., Dimitz, S., Werwent, J.J., McPheeters, H. (1969) Home vs Hospital Care for Schizophrenics. Journal of the American Medical Association. 178, 177-181.

Paton, R.(ed) (1984) Organizations: Cases, Issues, Concepts. London: Harper and Row.

Payne, R.L., Mansfield, R. (1973) Relationship of perceptions of organisational climate to organisationsl structure, context and hierarchical position. Administrative Science Quarterly. 18, 515-26.

Payne, R.L., Fineman, S., Wall, T.D. (1976) Organizational Climate and Job Satisfaction: A Conceptual Synthesis. Organizational Behavior and HUman Performance. 16, 45-62.

Pollock, L.C. (1987) Community Psychiatric Nursing Explained: An Analysis of the Views of Patients, Carers, and Nurses. PhD thesis. Edinburgh University.

Pollock, L.C. (1988) The work of the Community Psychiatric Nurse. Journal of Advanced Nursing. 13, 537-545.

Pollock, L.C. (1989) Community Psychiatric Nursing: Myth and Reality. RCN Research Series. Saltoun Press.

Porter, L.W., Lawler, E.C., Hackman, J.R. (1975) Behavior in Organisations. New York: McGraw Hill.

Pritchard, R.D., Karasick, B.W. (1973) The Effects of Organizational Climate on Managerial Job Performance and Job Satisfaction. Organizational Behavior and HUman Performance. 9, 126-146.

Pugh, D.S., Hickson, D.J. (1976) Organisational Structure in its Context: The Aston Programme. Farnborough: Saxon House.

Pugh, D.S., Hinings, C.R.(eds) Organisational Structure: extensions and replications. Farnborough: Saxon House.

Renton, C.A., Affleck, J.W., Carstairs, G.M. (1963) A Follow-Up of Schizophrenic Patients in Edinburgh. Acta Psychiatrica Scandinavica. 39, 548-581.

Robinson, A.D.T., McCreadie, R.G. (1986) The Nithsdale Schizophrenia Survey V. Follow-up of Tardive Dyskinesia at 3.5 years. British Journal of Psychiatry. 149, 621-623.

Schneider, B. (1972) Organizational Climate: Individual preferences and organisational relaities. Journal of Applied Psychology. 56,211-217.

Schneider, B. (1975) Organizational Climate: Individual preferences and organisational realities revisited. Journal of Applied Psychology. 60, 459-465.

Schneider, B. (1975) Organisational Climate: An Essay. Personnel Psychology. 28, 447-479.

Scott, W.R. (1986) Systems Within Systems: The Mental Health Sector. In Scott, W.R., Black, B.L. The Organisation of Health Services: Societal and Community Systems. London: Sage Publications.

Scottish Health Service Statistics (1991). HMSO: Edinburgh.

Shaw, F.E. Nursing Culture, Communication Rules and Job Satisfaction in Geriatric Long Stay Wards. Ph.D. Thesis. University of Edinburgh.

Simmons, S., Brooker, C. (1986) Community Psychiatric Nursing: A Social Perspective. London: Hiennemann.

Sims, H.P., Lafollette, W. (1975) An Assessment of the Litwin and Singer Organization Climate Questionnaire. Personnel Psychology. 28, 19-38.

Sladden, S. (1977) Psychiatric Community Nursing: A Study of a Working Situation. PhD thesis, Edinburgh University.

Sladden, S. (1979) Psychiatric Nursing in the Community: A Study of a Working Situation. Edinburgh: Churchill Livingston.

Taguiri, R., Litwin, G.H.(eds) (1968) Organizationsl Climate: exploration of a concept. Boston: Harvard University Press.

Thomson, R.V. (1982) Community Psychiatric Nursing in Clwyd: a comparative study of community psychiatric nursing in north and south Clwyd. Thesis for degree of M.Sc. University of Manchester.

Towell, D. (1975) Understanding Psychiatric Nursing. London: Royal College of Nursing.

Turner, G.N. (1984) A Census of Out-patients Attending for Depot medication at a Glasgow Psychiatric Hospital. Health Bulletin. 42(3), 141-145.

Waltz, C.F., Strickland, O.L., Lenz, E.R. (1984) Measurement in Nursing Research. Philadelphia: F.A. Davis Company.

Weber, M. (1947) The theory of social and economic organisation. Translated by Henderson, A.M., Parsons, T.(ed). New York: Free Press.

White, E. (1993) Community psychiatric nursing 1980 to 1990: a review of organization, education and practice. In Brooker, C. White, E.(eds) Community Psychiatric Nursing: A research perspective Volume 2. London: Chapman and Hall.

Woof, K., Goldberg, D.P., Fryers, T. (1988) The Practice of Community Psychiatric Nursing and Mental Health Social Work in Salford. British Journal of Psychiatry. 152, 783-792. Woof, K.,

Zola, I.K., McKinlay, J.B.(eds) (1974) Organization Issues in the Delivery of Health Services. New York: Millbank Memorial Fund.

APPENDICES

INCIDENT RECORD FORM

CASE NUMBER: DATE: SETTING:

SECTION 1: NURSE DETAILS

IF FIRST OBSERVATION FOR THIS NURSE PROCEED. OTHERWISE COPY DETAILS FROM CASE NUMBER:

NAME:	IDENTITY CODE 1

	1	2	3	4	
GRADE:	ENROLLED NURSE	STAFF NURSE	CHARGE NURSE	CPN	2

	1	2	3	
QUALIFICATION IF CPN:	CPN NO POST BASIC	CPN WITH POST BASIC	NOT CPN	3

	1	2	3	4	5	
CONTINUOUS EMPLOYMENT IN MENTAL HEALTH CARE:	LESS THAN 6 MONTHS	PLUS 6 MONTHS TO ONE YEAR	PLUS ONE YEAR TO TWO YEARS	PLUS TWO YEARS TO FIVE YEARS	OVER FIVE YEARS	4

	1	2	3	4	5	6	7	8	
NUMBER OF DEPOT INJECTIONS GIVEN IN EACH MONTH:	0 - 5	6 - 10	11 - 15	16 - 20	21 - 25	26 - 30	31 - 35	OVER 35	5

	1	2	3	4	5	6	7	8	
NUMBER OF CLIENTS SEEN FOR DEPOT INJECTION EACH MONTH:	0 - 5	6 - 10	11 - 15	16 - 20	21 - 25	26 - 30	31 - 35	OVER 35	6

NUMBER OF CLIENTS ON FORMAL CASELOAD OR SETTING RECORDS	7	NUMBER OF CLIENTS FROM WITHIN FORMAL CASELOAD OR SETTING RECORDS(ITEM 7 RECEIVING DEPOT DRUGS	8	NUMBER OF CLIENTS OUTWITH FORMAL CASELOAD OR SETTING RECORDS RECEIVING DEPOT DRUGS	

GIVES INJECTIONS IN DEPOT CLINIC				GIVES INJECTIONS AT HOME VISITS				GIVES INJECTIONS IN OTHER SETTING				IF OTHER SETTING USED SPEC TYPE FOR LATER CODING
1	2	SCORE	10	1	2	SCORE	11	1	2	SCORE	12	TYPE
YES	NO			YES	NO			YES	NO			

SECTION 3: CLIENT DETAILS

IF FIRST OBSERVATION FOR THIS CLIENT PROCEED. OTHERWISE COPY DETAILS FROM CASE NUMBER: [ ]

NAME:	IDENTITY CODE 22

AGE IN YEARS:	23

	1	2	24
SEX:	MALE	FEMALE	

	1	2	3	4	5	25
DEPOT INJECTION FREQUENCY:	WEEKLY	FORTNIGHTLY	THREE WEEKLY	FOUR WEEKLY	LONGER	

	1	2	IF YES DETAILS:	26
OTHER ORAL PSYCHOTROPIC:	YES	NO		

	1	2	IF YES DETAILS:	27
ORAL ANTI-PARKINSONIAN:	YES	NO		

	1	2	IF YES DETAILS:	28
TAKES OTHER DRUGS:	YES	NO		

	1	2	3	4	5	6	7	29
PERSON WHO HELPS CLIENT MOST:	PARENTS	SIBLINGS	SPOUSE	CHILDREN	OTHER RELATIVES	FRIENDS	HEALTH STAFF	

	1	2	IF YES DETAILS	30	ACCOMODATION DETAILS FOR LATER CODING - INDEX
LIVES WITH OTHERS:	YES	NO			

CTION 2: SETTING DETAILS

FIRST OBSERVATION FOR THIS SETTING PROCEED. OTHERWISE COPY DETAILS FROM CASE NUMBER: [ ]

NAME OF SETTING:	IDENTITY CODE 14

	1	2	3	4	IF OTHER GIVE DETAILS:	15
TYPE OF SETTING:	HOSP CLINIC	H. CENTRE	CPN OFF.	OTHER		[ ]

TOTAL CLIENTS SERVED BY SETTING/EACH CPN CASELOAD	16

CLIENTS WITHIN ABOVE TOTAL RECEIVING DEPOT:	17

	1	2	3	4	5	6	18
TYPE OF DEPOT RECORDS USED:	NO RECORDS	KARDEX ONLY	CARE PLAN ONLY	KARDEX AND CARE PLAN	SPECIFIC DEPOT RECORD ONLY	SPECIFIC DEPOT RECORD AND OTHER	[ ]

	1	2	3	19
NORMAL ARRANGEMENTS FOR DRUG ADMINISTRATION:	BY DATE ONLY	BY DATE AND TIME	NONE	[ ]

	1	2	20
APPOINTMENT CARD PROVIDED:	YES	NO	[ ]

	1	2	21
APPOINTMENT TO SEE NAMED NURSE:	YES	NO	[ ]

OBSERVATION SCHEDULE

OBSERVATION START TIME:

OBSERVATION FINISH TIME:

DURATION OF INTERACTION IN MINUTES:		32

FIRST CONTACT NURSE/CLIENT	1	2	33
	YES	NO	

CRITERIA	NO ACTION SCORE=0	ENQUIRY SCORE=1	EXAMINATION SCORE=2	DESCRIBE EXAMINATION TECHNIQUE USED	SCORE	
CHECKS FOR DRY MOUTH						34
CHECKS FOR TREMOR						35
CHECKS GAIT/POSTURE						36
CHECKS FOR TONGUE/FACIAL MOVEMENT						37
CHECKS FOR BLURRED VISION						38
CHECKS INJECTION SITE STATE						39

	YES=1	NO=0	COMMENT	SCORE	
ALTERNATES FROM LAST SITE USED					40
CHECKS COMPLIANCE WITH ORAL DRUGS (if no oral prescribed then score = 1) (if on oral score for 'no' = -1)					41
CORRECT MEDICATION GIVEN					42
ARRANGES NEXT APPOINTMENT					43
ENQUIRY - SLEEP PATTERN					44
ENQUIRY - NUTRITION					45
ENQUIRY - GENERAL HEALTH STATUS					46
ENQUIRY - PERSONAL HYGIENE/SELF CARE					47
TAKES TEMPERATURE					48
TAKES PULSE					49
TAKES BLOOD PRESSURE					50
ENQUIRY - FINANCIAL PROBLEMS					51
ENQUIRY - RELATIONSHIPS WITH OTHERS					52
ENQUIRY - DAILY ACTIVITIES					53
ENQUIRY - 'ANY OTHER PROBLEMS'					54
ENQUIRY - CLIENTS CONSENTS TO DEPOT					55

PAGE 3 - NURSES STATED CONCERNS DURING OBSERVATION.

'DURING YOUR ADMINISTRATION OF DEPOT MEDICATION TO (CLIENT) WHAT WERE YOUR MAJOR CONCERNS REGARDING THE NURSING CARE ISSUES FOR THIS CLIENT'.

IS THIS CLIENT PART OF YOUR FORMAL CASELOAD/SETTING RECORD.

1	2
YES	NO

56

NAME: CODE NO.: SETTING NO.:

PLEASE RETURN THIS QUESTIONNAIRE IN THE ENVELOPE PROVIDED UNLESS ALTERNATIVE ARRANGEMENTS HAVE BEEN AGREED

SECTION: 1

This section deals with the subject of the INTRODUCTION OF NEW IDEAS AND INNOVATIONS.

Relating to this subject there are six pairs of statements in this section. Please read each pair of statements carefully and indicate the one, of each pair, which best represents your work setting by ticking the box adjacent to the statement of your choice. Remember to tick only one box for each pair of statements.

In addition for each pair please make a short comment describing the reasons for your choice. Should you wish to make further comments there is space provided at the end of the section. Related to each pair of statements, below the space for comments, please indicate your personal opinion by circling a number ranging from 1 to 7, depending on the extent to which you feel the subject is unimportant, or essential, for good nursing practice.

Section: 1 Pair: 1

LEAVE BLANK

a) PEOPLE HERE ARE ENCOURAGED TO SUGGEST NEW IDEAS ☐

b) PEOPLE HERE ARE NOT ENCOURAGED TO SUGGEST NEW IDEAS ☐

COMMENTS:

OPINION: INTRODUCING NEW IDEAS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 1 Pair: 2

a) IN THIS SETTING ATTEMPTS ARE MADE TO IMPLEMENT NEW IDEAS ☐

b) NEW IDEAS ARE RARELY PUT INTO PRACTICE IN THIS SETTING ☐

COMMENTS:

OPINION: ATTEMPTING TO TRY NEW IDEAS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

LEAVE BLANK

Section: 1 Pair: 3

a) THERE ARE OCCASIONS HERE WHEN RULES CAN BE BROKEN OR IGNORED

b) IN THIS SETTING NURSES MUST OBEY THE RULES AT ALL TIMES

COMMENTS:

OPINION: ENSURING THAT RULES ARE ALWAYS OBEYED BY NURSES IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 1 Pair: 4

a) IN THIS SETTING THERE IS A WILLINGNESS TO TRY A NEW IDEA IF THERE ARE POSSIBLE BENEFITS TO BE HAD

b) THERE IS A RELUCTANCE HERE TO TRY A NEW IDEA IN CASE SOMETHING GOES WRONG

COMMENTS:

OPINION: THE ELEMENT OF RISK IN TRYING A NEW IDEA IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 1 Pair: 5

a) IN THIS SETTING THERE ARE ADDITIONAL REWARDS FOR GOOD NURSES

b) NO MATTER HOW HARD NURSES WORK HERE THERE ARE FEW REWARDS FOR EXTRA EFFORT

COMMENTS:

OPINION: HAVING REWARDS FOR NURSES WHO WORK HARD IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 1 Pair: 6

LEAVE BLANK

a) IN THIS SETTING NURSES RECEIVE RECOGNITION AND PRAISE FOR A JOB WELL DONE

b) PRAISE AND RECOGNITION ARE RARE HERE NO MATTER HOW HARD NURSES WORK

COMMENTS:

OPINION: NURSES RECEIVING RECOGNITION AND PRAISE FOR THEIR EFFORTS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

ADDITIONAL COMMENTS ON THIS SECTION:

SECTION: 2

This section deals with the subject of the EFFECTIVE ORGANISATION OF NURSING ACTIVITY.

Relating to this subject there are six pairs of statements in this section. Please read each pair of statements carefully and indicate the one, of each pair, which best represents your work setting by ticking the box adjacent to the statement of your choice. Remember to tick only one box for each pair of statements.

In addition for each pair please make a short comment describing the reasons for your choice. Should you wish to make further comments there is space provided at the end of the section. Related to each pair of statements, below the space for comments, please indicate your personal opinion by circling a number ranging from 1 to 7, depending on the extent to which you feel the subject is unimportant, or essential, for good nursing practice.

Section: 2 Pair: 1

LEAVE BLANK

a) IN THIS SETTING MOST NURSING PROCEDURES ARE THE SUBJECT OF WRITTEN POLICY STATEMENTS ☐

b) THERE ARE FEW WRITTEN POLICY STATEMENTS HERE REGARDING NURSING PROCEDURES ☐

COMMENTS:

OPINION: HAVING WRITTEN PROCEDURES FOR NURSING ACTIVITIES IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 2 Pair: 2

a) THERE ARE A LOT OF RULES AND REGULATIONS HERE WHICH NURSES ARE EXPECTED TO OBEY ☐

b) THERE ARE FEW RULES AND REGULATIONS HERE WHICH NURSES ARE EXPECTED TO OBEY ☐

COMMENTS:

OPINION: HAVING RULES WHICH DEAL WITH MOST DAY TO DAY SITUATIONS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 2 Pair: 3

LEAVE BLANK

a) NURSES HERE ARE INVOLVED IN MOST OF THE DECISIONS WHICH AFFECT THEIR DAY TO DAY WORK

b) NURSES HERE TEND NOT TO PARTICIPATE IN DECISIONS WHICH AFFECT THEIR DAY TO DAY WORK

COMMENTS:

OPINION: NURSE BEING INVOLVED IN MAKING DECISIONS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 2 Pair: 4

a) NURSES WORKING HERE ARE GIVEN ENOUGH INFORMATION TO CARRY OUT THEIR DAY TO DAY WORK

b) NOT ENOUGH INFORMATION IS GIVEN TO NURSES IN THIS SETTING ABOUT SOME ASPECTS OF THEIR DAY TO DAY WORK

COMMENTS:

OPINION: HAVING SUFFICIENT INFORMATION IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 2 Pair: 5

a) IN THIS SETTING MOST DECISIONS ARE MADE PROMPTLY

b) IN THIS SETTING THERE IS OFTEN A DELAY IN DECISIONS BEING MADE

COMMENTS:

OPINION: MAKING DECISIONS PROMPTLY IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

:tion: 2 Pair: 6

LEAVE BLANK

INFORMATION IS COMMUNICATED EFFECTIVELY IN THIS SETTING

IN THIS SETTING THERE ARE OFTEN DELAYS OR DIFFICULTIES IN OBTAINING INFORMATION

MENTS:

TION: GOOD COMMUNICATION IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

DITIONAL COMMENTS ON THIS SECTION:

SECTION: 3

This section deals with the subject of the ROLE OF NURSING STAFF.

Relating to this subject there are six pairs of statements in this section. Please read each pair of statements carefully and indicate the one, of each pair, which best represents your work setting by ticking the box adjacent to the statement of your choice. Remember to tick only one box for each pair of statements.

In addition for each pair please make a short comment describing the reasons for your choice. Should you wish to make further comments there is space provided at the end of the section. Related to each pair of statements, below the space for comments, please indicate your personal opinion by circling a number ranging from 1 to 7, depending on the extent to which you feel the subject is unimportant, or essential, for good nursing practice.

Section: 3 Pair: 1

LEAVE BLANK

a) I HAVE A JOB DESCRIPTION WHICH CLEARLY SETS OUT THE RANGE OF MY RESPONSIBILITIES

b) MY JOB DESCRIPTION DOES NOT ACCURATELY REFLECT THE RANGE OF MY RESPONSIBILITIES

COMMENTS:

OPINION: HAVING AN ACCURATE JOB DESCRITION IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 3 Pair: 2

a) THE DEMANDS MADE OF ME BY OTHER STAFF AT WORK ARE COMPATIBLE WITH MY JOB

b) THERE ARE TIMES WHEN THE DEMANDS MADE OF ME BY OTHERS IS NOT COMPATIBLE WITH MY JOB

COMMENTS:

OPINION: THAT DEMANDS MADE OF NURSES SHOULD ALWAYS BE COMPATIBLE WITH THEIR JOB IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

LEAVE BLANK

Section: 3 Pair: 3

a) I ONLY TAKE INSTRUCTIONS FROM, AND REPORT BACK TO, MY NURSE MANAGER ☐

b) I AM EXPECTED TO TAKE INSTRUCTIONS FROM, AND REPORT BACK TO, OTHER STAFF IN ADDITION TO MY NURSE MANAGER ☐

COMMENTS:

OPINION: HAVING A SINGLE BOSS TO WHOM YOU REPORT TO IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 3 Pair: 4

a) I AM ALWAYS ABLE TO RESPOND TO THE DEMANDS OTHERS MAKE OF ME ☐

b) I AM SOMETIMES ABLE TO RESPOND TO THE DEMANDS MADE OF ME BY OTHERS ☐

COMMENTS:

OPINION: BEING ALWAYS ABLE TO MEET THE DEMANDS OF OTHERS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 3 Pair: 5

a) I HAVE BEEN DELAGATED AUTHORITY TO MAKE DECISIONS ON SOME MATTERS WITHOUT GETTING APPROVAL ELSEWHERE ☐

b) THER ARE FEW MATTERS ON WHICH I CAN MAKE DECISIONS WITHOUT GETTING APPRPVAL ELSEWHERE ☐

COMMENTS:

OPINION: NURSES HAVING A DEGREE OF AUTHORITY TO MAKE DECISIONS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 3 Pair: 6

LEAVE BLANK

a) I HAVE THE SKILLS AND KNOWLEDGE SUITED TO THE TYPE OF WORK I AM EXPECTED TO CARRY OUT

b) MY SKILLS AND KNOWLEDGE ARE NOT ALWAYS SUITED TO THE NATURE OF MY DUTIES

COMMENTS:

OPINION: HAVING THE APPROPRIATE SKILLS AND KNOWLEDGE FOR YOUR JOB IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

ADDITIONAL COMMENTS ON THIS SECTION:

SECTION: 4

This section deals with the way nursing staff SUPPORT AND ENCOURAGE EACH OTHER.

Relating to this subject there are six pairs of statements in this section. Please read each pair of statements carefully and indicate the one, of each pair, which best represents your work setting by ticking the box adjacent to the statement of your choice. Remember to tick only one box for each pair of statements.

In addition for each pair please make a short comment describing the reasons for your choice. Should you wish to make further comments there is space provided at the end of the section. Related to each pair of statements, below the space for comments, please indicate your personal opinion by circling a number ranging from 1 to 7, depending on the extent to which you feel the subject is unimportant, or essential, for good nursing practice.

Section: 4 Pair: 1

LEAVE BLANK

a) IN THIS SETTING PEOPLE ARE SUPPORTIVE IF YOU HAVE A PROBLEM ☐

b) PEOPLE HERE TEND NOT TO BE SUPPORTIVE IF YOU HAVE A PROBLEM ☐

COMMENTS:

OPINION: OTHER PEOPLE BEING SUPPORTIVE TO YOU AT WORK IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 4 Pair: 2

a) PEOPLE IN THIS SETTING HAVE TRUST IN ONE ANOTHER ☐

b) THERE IS A LACK OF TRUST AMONGST COLLEAGUES IN THIS SETTING ☐

COMMENTS:

OPINION: BEING ABLE TO TRUST, AND BE TRUSTED BY, COLLEAGUES IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

LEAVE BLANK

Section: 4 Pair: 3

a) MOST WORKING RELATIONSHIPS HERE TEND TO BE FORMAL

b) WORKING RELATIONSHIPS HERE TEND TO BE INFORMAL

COMMENTS:

OPINION: HAVING FORMAL WORK RELATIONSHIPS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 4 Pair: 4

a) GUIDANCE AND ADVICE IS OFFERED HERE SHOULD STAFF REQUIRE IT

b) GUIDANCE AND ADVICE ARE RARELY OFFERED TO STAFF IN THIS SETTING

COMMENTS:

OPINION: FREELY AVAILABLE GUIDANCE AND ADVICE AT WORK IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 4 Pair: 5

a) IF A MISTAKE DOES HAPPEN CRITICISMS ARE MADE IN A CONSTRUCTIVE MANNER

b) IF A MISTAKE DOES HAPPEN PEOPLE ARE QUICK TO CRITICISE AND ALLOCATE BLAME

COMMENTS:

OPINION: CRITICISMS BEING MADE IN A CONSTRUCTIVE MANNER IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 4 Pair: 6

LEAVE BLANK

a) THERE IS A SENSE OF TEAM SPIRIT AMONGST STAFF HERE ☐

b) THERE IS A LACK OF TEAM SPIRIT IN THIS SETTING ☐

COMMENTS:

OPINION: A SENSE OF TEAM SPIRIT AT WORK IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

ADDITIONAL COMMENTS ON THIS SECTION:

SECTION: 5

This section deals with the subject of STANDARDS OF NURSING CARE.

Relating to this subject there are six pairs of statements in this section. Please read each pair of statements carefully and indicate the one, of each pair, which best represents your work setting by ticking the box adjacent to the statement of your choice. Remember to tick only one box for each pair of statements.

In addition for each pair please make a short comment describing the reasons for your choice. Should you wish to make further comments there is space provided at the end of the section. Related to each pair of statements, below the space for comments, please indicate your personal opinion by circling a number ranging from 1 to 7, depending on the extent to which you feel the subject is unimportant, or essential, for good nursing practice.

Section: 5 Pair: 1

LEAVE BLANK

a) STANDARDS OF NURSING CARE ARE OFTEN DISCUSSED IN THIS SETTING ☐

b) STANDARDS OF NURSING CARE ARE RARELY DISCUSSED IN THIS SETTING ☐

COMMENTS:

OPINION: REGULARLY DISCUSSING STANDARDS OF NURSING CARE IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 5 Pair: 2

a) THE NURSING CARE PRACTICED HERE IS BASED ON A CARE PLAN FOR EACH INDIVIDUAL PATIENT/CLIENT ☐

b) THE NURSING CARE PRACTICED HERE TENDS TO BE ORGANISED AROUND THE VARIOUS JOBS WHICH HAVE TO BE DONE ☐

COMMENTS:

OPINION: HAVING INDIVIDUAL CARE PLANS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

LEAVE BLANK

Section: 5 Pair: 3

a) THE STANDARDS OF NURSING CARE ACHIEVED ARE REGULARLY MONITORED ☐

b) IN THIS SETTING STANDARDS OF NURSING CARE ARE NOT REGULARLY MONITORED ☐

COMMENTS:

OPINION: REGULARLY MONITORING STANDARDS OF NURSING CARE IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 5 Pair: 4

a) ACTIVE STEPS ARE TAKEN HERE TO ENSURE THAT NURSING STAFF KEEP UP TO DATE WITH CLINICAL/PROFESSIONAL DEVELOPMENTS ☐

b) NO ACTIVE STEPS ARE TAKEN HERE TO ENSURE THAT NURSING STAFF KEEP UP TO DATE WITH CLINICAL/PROFESSIONAL DEVELOPMENTS ☐

COMMENTS:

OPINION: NURSES KEEPING UP TO DATE WITH DEVELOPMENTS IS: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 5 Pair: 5

a) STAFF HERE ARE GIVEN SUFFICIENT RESOURCES TO ENSURE THAT A HIGH STANDARD OF NURSING CARE IS ACHIEVED ☐

b) A LACK OF RESOURCES MEANS THAT A HIGH STANDARD OF NURSING CARE IS NOT REGULARLY ACHIEVED ☐

COMMENTS:

OPINION: TO ACHIEVE A HIGH STANDARD OF NURSING CARE RESOURCES ARE: 1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

Section: 5 Pair: 6

LEAVE BLANK

a) EXPECETED STANDARDS OF NURSING CARE ARE CLEARLY DEFINED IN THIS SETTING

b) IN THIS SETTING EXPECTED STANDARDS OF CARE HAVE NOT BEEN CLEARLY DEFINED

COMMENTS:

OPINION: HAVING EXPECTED STANDARDS OF NURSING CARE DEFINED IS:

1 2 3 4 5 6 7

UNIMPORTANT ESSENTIAL

ADDITIONAL COMMENTS ON THIS SECTION:

with families: a practical approach to working with families of the mentally ill. *Psychosocial Rehabilitation Journal*, 8, 77–84.,

Spaniol, L., Jung, H., Zipple,A. *et al.* (1987) Families as a resource in the rehabilitation of the severely psychiatrically disabled, in *Families of the Mentally Ill* (eds A. Hatfield and H. Lefficy), Cassell Educational, London.

Stirling, J., Tantam, D., Thomas, P. *et al.* (1991) Expressed emotion and early onset schizophrenia: a one-year follow-up. *Psychological Medicine* (in press).

Strachan, A. (1986) Family intervention for the rehabilitation of schizophrenia: towards protection and coping. *Schizophrenia Bulletin*, 12, 678–98.

Suy, E., Woestenborghs, R. and Heykants, J.(1982) Bioavailability and clinical effects of two different concentrations of haloperidol decanoate. *Current Therapeutic Research*, 31, 982–91.

Tarrier, N. and Barrowclough, C. (1986) Providing information to relatives about schizophrenia: some comments. *British Journal of Psychiatry*, 149, 458–63.

Tarrier, N., Barrowclough, C., Vaughn, C. *et al.*(1988) The community management of schizophrenia: a controlled trial of a behavioural intervention with families to reduce relapse. *British Journal of Psychiatry*, 153, 532–42.

Tyrer, P., Hawksworth, J., Hobbs, R. *et al.* (1990) The role of the community psychiatric nurse. *British Journal of Hospital Medicine*, 43, 439–42.

Vaughn, C. and Leff, J. (1976) The influence of family and social factors on the course of psychiatric illness. *British Journal of Psychiatry*, 129, 125–37.

Vaughn, C. (1989) Annotation: expressed emotion in family relationships. *Journal of Child Psychology and Psychiatry*, 30(1), 13–22.

White, E. (1990) *The Third Quinquennial National Survey of Community Psychiatric Nursing, Research Monograph*, Department of Nursing, University of Manchester.

White, E. and Brooker, C. (1991) The care programme approach. *Nursing Times*, 87(12), 66–7.

Wooff, K., Goldberg, D. and Fryers, T. (1988) The practice of community psychiatric nursing and mental health social work in Salford. *British Journal of Psychiatry*, 152, 783–92.

CHAPTER FOUR

Client/CPN contact during the administration of depot medications: implications for practice

Gordon Turner

INTRODUCTION

The findings and discussion presented in this chapter are extracted from a larger study and, consequently, only a small part of the data collected can be included. The content will deal with issues related to administration of depot neuroleptic drugs, and to data describing the standard and content of observed nurse and client contacts involving the administration of depot drugs. While drug-related issues might be seen by some as being more the province of the medical profession, the rationale and usage of depot drugs do have important impact on the workload, and therefore the clinical practice, of nurses. The data reported here focuses on the nature of the nursing involvement in the administration of depot neuroleptic drugs.

It is hoped that this subject will be of particular relevance to practising CPNs, many of whom will have personal experience of, and may be currently involved in, the administration of depot drugs. These findings may also be of interest to medical practitioners and, hopefully, all those involved in the provision of community services, especially those services related to mental health care.

The data reported in this paper are extracted from a thesis to be submitted to the University of Edinburgh. The study was supported by the award of a Nursing Research Training Fellowship by the Scottish Home and Health Department. Opinions expressed are those of the author and do not necessarily represent the views of the funding body.

The findings here are, of course, specific to the study area but, as will be shown, the variations in practice across a single health board do raise issues which should be of interest to all practising CPNs and their managers.

BACKGROUND

Schizophrenia and chemotherapy

In general terms, it can be reasonably assumed that clients receiving depot drugs will have been diagnosed medically as having a major mental health disorder of the type encompassed by the term schizophrenia.

Within the mental illness services the care of the schizophrenic client has been described as 'the heartland of psychiatry and the core of its clinical practice' (Kendall, 1983). Although the assessment of active 'symptoms' is important, particularly in younger people, some clients will, eventually, present with a more chronic condition in which the acute symptoms are minimal, but where social functioning is grossly impaired. This 'defect state' is described by Kendall (1983):

> He becomes apathetic, no longer strives, no longer cares. At the same time, and perhaps fundamentally for the same reason, he loses interest in other people and his capacity to form enduring emotional relationships is reduced ... It is this apathy and emotional blunting which make schizophrenia the terrible illness it is, because they are permanent changes in the personality which handicap the subject in every sphere.

Among such persons, then, it is probable that some will have been ill for many years and will have accrued considerable personal and social handicaps.

Neuroleptic, or anti-psychotic, drugs are closely associated with the management of schizophrenia. When first introduced in the 1950s they were available only as short-acting oral drugs and, as a consequence, compliance with oral drugs quickly proved to be a major obstacle to treatment.

Given the known efficacy of neuroleptic drugs in reducing relapse rates (Leff and Wing, 1971; Pasamanick, Scarpitti, Lefton, *et al.* 1969), compliance is obviously a key factor in effective clinical management, at least from the 'symptom control' point of view. The requirement for clients to take tablets at intervals throughout the day has obvious implications, given the potentially insightless nature of the client with schizophrenia.

By the mid-1960s neuroleptic drugs became available in depot format, which allowed administration by deep intramuscular injections to occur, for most, at intervals of between one and four weeks. This change in the mode of drug administration improved treatment by reducing the risk of noncompliance (Eberhard and Hellbom, 1986), as clients have to be seen regularly by a

health care professional in order to receive an injection. These drugs proved to hold so many advantages that by the 1980s Eberhard and Hellbom (1986) viewed that neuroleptic drugs, particularly in the depot form, had become 'the mainstay in the treatment of chronic schizophrenia'.

However, one area of concern regarding some neuroleptic drugs, and depot types especially, are the side-effects. Of these, the most important are the three types of movement disorder: dystonia, producing involuntary muscle contractions; akathisia, which commonly presents as a discomfort in the arms and legs resulting in marked restlessness; and tardive dyskinesia, which is characterized by movements of the mouth and tongue, and may be both irreversible and resistant to treatment. The incidence of tardive dyskinesia is common and has been found to affect between 27% and 31% of schizophrenic clients (Robinson and McCreadie, 1986).

A number of studies have indicated that the administration of depot drugs to schizophrenic clients living in the community is extensive (Cheadle, Freeman and Korer, 1978; Freeman and Alpert, 1986; McCreadie, Robinson and Wilson, 1984). In a group of 44 out-patients described by Turner (1984), depot drugs had been a component of treatment for an average of 7.5 years, with injections being administered, on average, every 2.3 weeks. Surveys of prescribing practice (Clark and Holden, 1987; Holloway, 1988) confirm the popularity of depot drugs in the treatment of clients with schizophrenia.

The management of clients with schizophrenia living in the community is a key challenge for mental health services in view of the move to discharge a greater proportion of such clients into the community. The use of depot drugs will place certain demands upon the health services, but will also provide an opportunity for frequent assessment, ensuring that drug treatment, social factors and the personal circumstances of each client can be monitored regularly, possibly over long periods of time for a population with major mental health care needs.

Failure to fully utilize this contact might not only prejudice the abilities of such clients to remain in the community but might also indicate an unacceptable standard of nursing intervention.

Nursing involvement in depot administration

The nature of the nursing input to the care of such clients is of particular importance, since most will be seen regularly by nurses to receive their injection. For many clients this will represent their most frequent contact with health services. However, there is evidence to suggest that the opportunities afforded by the depot injection event are not always being fully utilized.

The nursing role in relation to depot administration has not been defined specifically, although some researchers have commented on the practices involved. Thomson (1982) found that nurses gave depot administration a low

priority, while Turner (1984) found that depot administration to out-patients occurred informally, and was not recognized by the hospital concerned as requiring any particular facilities.

In one study it was found that 41% of all nursing contacts with clients with schizophrenia occurred at depot clinics, but that these contacts accounted for only 4% of the nurses' working time, with an average contact duration lasting only three minutes (Sladden, 1979). Thomson (1982) also raises the topic of brevity, describing a situation where injections were given to different clients, each in separate locations, within a relatively short period of time. Hunter (1978), in a study of the provision of care to clients with schizophrenia, commented that:

> Disappointment was expressed by some of the patients and caregivers about changes they had experienced starting with the patient being given Moditen [a depot drug] injections. A number said this was associated with the stopping of conversation with the nurse, and they missed this.

Wooff, Goldberg and Fryers (1988) contrasted the activities of CPNs and social workers and found that the mean duration of contacts with clients with schizophrenia was substantially shorter for the CPN group, and that drugs were administered in 30% of CPN contacts. It was suggested that the main thrust of CPN involvement was related to the administration of drugs to the exclusion of other types of nursing activity, concluding that:

> The CPNs' emphasis on the administration of drug in their interactions with their schizophrenic clients confirmed the observer's subjective impressions of shortcomings in arrangements for the long-term care of these clients and their families. The observer noted that in the 'injection clinics' questions about symptoms were often made in the language and tone associated with an ordinary social enquiry; and a tendency to avoid upsetting clients and to reassure them, rather than discuss strategies for dealing with problems, was observed.
>
> (Wooff *et al.*, 1988)

This evidence raises important questions for research into the activities of nurses and the ways in which they exploit the contact required by depot drug administration.

It would appear that some nurses might see their role mainly as that of 'injection givers', since the duration of some contacts suggests that it is unlikely that any other nursing interventions could occur with any consistency. This would contrast sharply with any aims to provide a more comprehensive service, thereby maximizing the potential for clients to enjoy meaningful community living for as long as is possible.

Therefore, in view of the frequency and potential value of the depot injection contacts and the previous evidence regarding the involvement of nurses, a study was undertaken to describe in some detail nursing activity during these

contacts in order to identify the extent to which nurses constructively utilized this important therapeutic opportunity.

RESEARCH METHODS

In order to obtain information regarding current standards of nursing care (care) during the administration of depot drugs to out-patients, a survey of nurse/client contacts, in the various settings involved, formed the main thrust of the study. Data on care was collected using an instrument constructed specifically for this purpose, and involved the use of both non-participant observation of nurse/client contacts and subsequent discussion about the contact with the nurse concerned.

The use of non-participant observation, involving the presence of the researcher during the contact, did not prove problematic, because in the study area the presence of learner nurses during such contacts was common practice, so that clients were well used to the presence of a second person.

Waltz, Strickland and Lenz (1986) identify two principal approaches to measuring standards of care; the 'norm referenced' and the 'criterion referenced'. Norm referenced measurement involves comparing the performance of a subject with the known performance of others, while criterion referenced measurement is used to determine whether or not a subject has exhibited a predetermined set of behaviours.

Since a previously established 'norm referenced' nursing care standard for depot administration was not available, a 'criterion referenced' instrument (Waltz *et al.*, 1986) was developed to measure standards of nursing care. This instrument (index) represents for the purposes of the study a standard of nursing care against which the nursing contacts observed could be compared, thereby revealing the patterns of, and any difference in, nursing practice. The selection of criteria for inclusion in the index was undertaken by obtaining a consensus of expert opinion, and also taking into to account prescriptive nursing interventions contained in the literature (Boettcher and Alderson, 1983; Irons, 1978). Individuals having relevant knowledge and experience of depot drug administration were identified to provide this expert opinion and were asked to identify the range of nursing interventions which they considered common to the administration of a depot drug in typical circumstances.

The 22 criteria identified by these experts, and subsequently included in the index, are those which, in the view of these experts, a nurse administering depot drug to a number of clients would find relevant. As one expert commented, these criteria should be in every nurse's 'armoury' of possible interventions when dealing with clients receiving depot drugs.

From the index an observation schedule and scoring system were developed. It was also anticipated that during observation the researcher might not correctly identify some interventions, due primarily to lack of familiarity with

nurse and client. Therefore after each contact, and after the client had left, nurses were invited to summarize their concerns during the contact about the client or any other related circumstances. Where this discussion indicated that an index item had been a factor in the nurse's actions but had not been identified by the researcher during observation, a score was awarded. For each contact the time duration to the nearest minute was documented, as was whether the client was part of the formal caseload of the nurse concerned.

From the pilot study some important assumptions were made regarding the standard of nursing care, in view of the practicalities of observation and ethical issues:

1. The prescribed dose of drug was administered by the nurse.
2. The injection would be administered in the most appropriate injection site, which was commonly an alternative site to the last site used. Again, the main study confirmed this with frequent references to 'which side today?'.
3. Immediately before the injection was given the nurse would ascertain that the proposed injection site was in a fit state to receive it.

Therefore, in view of these assumptions, for each observation a minimum index score of four could be achieved simply by a nurse giving an injection; the injection being a pre-requisite for inclusion in the study. Each injection was therefore presumed to be of the correct drug and dose, and was given into the most appropriate injection site after examination by the nurse. Field notes were used to document the pattern of the contacts, in particular the flow and content of conversation, any non-verbal interventions, or any other events of note (such as telephone interruptions).

Non-parametric (or 'distribution-free') statistical tests were used to analyse the data. The results were considered statistically significant, and the null hypothesis rejected, at the $p = 0.05$ level or less. While the majority of tables show mean values to summarize data, readers should note that the statistical techniques used are not those which involved the comparison of means.

SETTINGS, NURSES AND MANAGERIAL SECTORS

The study took place within the psychiatric services of a single health board and were encompassed by a single overall management structure within the health board. This structure was further subdivided into four 'managerial sectors', each having local management, but reporting to the unit general manager. From within the main study area, settings involved in the administration of depot drug to out-patients were identified at the conclusion of access negotiations, with data being collected from all those nurses who agreed to participate in the study.

During the main study 202 contacts between nurses and clients were observed, all involving the administration of a depot drug injections. These contacts were obtained in 16 different settings, and involved 17 nurses. Three types of settings and three types of nurses could be defined from the data collected, and proved valuable in exploring the patterns of care given across the different setting and nurse types, and the four managerial sectors.

Types of setting

Each of the 16 settings can be considered as being one of the three distinct types; hospital clinic, CPN office and health centre.

Hospital clinics (setting type 1). The two hospital clinics were situated in a large mental illness hospital and large acute general hospital, in the grounds of which a mental illness unit is based, which is managed from the mental illness hospital. The larger of the two hospital clinics, set in the acute hospital grounds, was well equipped and more spacious than the other hospital clinic, which took place in a small 'treatment room' within the out-patient complex. In both clinics, concurrent consultant clinics also took place.

CPN offices (setting type 2). The term 'CPN office' is not used within the study area, but is used here to identify those locations in the community used by CPNs for depot administration, other than multi-purpose local health centres. The six settings of this type appeared to be used primarily as bases for community nurses and health visitors. In some of these settings the room in which depot injections were given tended to be rather spartan, compared with health centres, and often had numerous posters targeted at pregnancy or child care issues.

In the CPN office settings there were usually no reception staff, and some nurses reported that telephone facilities could be problematic. Where screens were available they tended to be of the portable variety.

Health centres (setting type 3). Eight of the 16 settings studied were contained within local health centres. These settings all had reception staff, with consequent good communications, and more comfortable waiting areas. The rooms used all had fitted screens and, from the range of posters on display, were again most often used for nursing mothers and children.

Although hospital consultant staff were not available here, some nurses did appear to have a good relationship with some GPs based in the health centre, some of whom referred clients to the CPN concerned.

Types of nurse (CPN)

Nurses participating in the study were considered as belonging to one of three types of CPN, irrespective of their clinical grade. All nurses held the appropriate registered mental nurse (RMN) qualification.

CPN1. These nurses were employed as part of the community psychiatric nursing service, but had not obtained post-basic qualification in this specialty.

CPN2. These nurses were also employed as part of the community psychiatric nursing service but had obtained post-basic qualification in this speciality.

CPN3. These nurses, while having links with the community psychiatric nursing service, did not hold post-basic qualification in this specialty and were primarily hospital based. In this sample both the nurses in this type were based in the two hospital clinics.

Of the 17 nurses, 10 were CPNs with post-basic experience (CPN2). The five remaining CPN department-attached nurses had no post-basic qualification (CPN1), although some were awaiting confirmation of acceptance for post-basic training at the time of observation, with the remaining two nurses being hospital clinic based (CPN3).

Managerial sectors

As noted earlier, and while all the settings studied form part of a single managerial structure, there is a sub-structure of four managerial sectors, related primarily to the geography of the study area. Each of the managerial sectors contains a large mental illness hospital, which in some cases involves related, smaller, satellite hospitals. In each case the CPN department containing the responsible manager was located in the major hospital. Some CPNs may have a local base, where they maybe wholly or partly based, but continue to report to a manager located in the main hospital.

Managerial sector 1. The setting used in the pilot study was from managerial sector 1, which reduced the potential number of main study observations from this sector. The pilot setting was the only clinic based in a local health centre within this area. Both the settings in the main study were CPN offices.

Managerial sector 2. Both the settings in managerial sector 2 were the only two hospital clinics in the sample. Setting 2 also functioned as a clinic

dealing with the administration other drugs; this being the responsibility of the same nurse.

A health centre setting involved in depot administration in this managerial sector was not studied; the nurse concerned declining to participate.

Managerial sector 3. The clinics in managerial sector 3 were all located in local population centres. Of the four settings studied, two were based in local health centres and the remaining two in CPN offices. Facilities in both the health centre settings were good, while in one of the CPN offices the accommodation appeared to be particularly unsuitable.

Managerial sector 4. Managerial sector 4 accounted for eight of the 16 settings; and for six of the eight health centre-based settings, with the remaining two settings here being in CPN offices. The health centre accommodation, again like elsewhere, was noticeably better than other types. In one setting the nurse concerned was in the habit of playing music during contacts with clients.

Before leaving the issue of the various types of settings, it is worth noting specifically that data presented regarding hospital clinics (setting type 1), non-CPN attached nurses (CPN3) and managerial sector 2 will be identical since all the data regarding these types arise from the same observations.

APPOINTMENT ARRANGEMENTS, RECORDS AND CLIENTS

Appointment arrangements

The appointment arrangements were broadly similar in all 17 settings. The use of appointment cards was common, although there were occasions where the nurse had 'run out' of cards. Interestingly, the majority of these cards are supplied by depot manufacturers, with the names of particular drugs prominent on the card. While not a specific item of data, it is worth noting that there were several occasions when clients were given an appointment card (since these appeared to be regularly mislaid by clients) where the 'logo' on the card was not that of the drug prescribed.

On one of these occasions a nurse had to spend some time reassuring a client that their prescribed drug had not been changed, because the nurse had given the client an appointment card with the 'logo' of another drug (the nurse having none available for the prescribed drug).

In all cases clients could expect to see a particular nurse. In a number of cases nurses did inform clients that they would be unavailable to give the

next injection, and usually said which nurse would be in attendance instead. During contacts where the nurse was meeting the client for the first time, the nurses always introduced themselves by name before administering the injection. The use of specific appointment times was observed, primarily in those settings with managerial sector 4, where the setting caseload numbers tended to be smaller. In practice these timings appeared flexible, and on occasions there would be a gap between the departure of one client and the arrival of the next. It was apparent that in these settings a queue of clients awaiting injection rarely developed.

Records

The use of records proved to be more problematic in terms of categorization. Apart from prescription and drug recording sheets, both of which are mandatory and identical in all settings, the most common record (other that the appointment card) was the diary. In the diary nurses would 'tick off' each client as they attended and, at the same time as amending the appointment card, would record the client's name on the next due date. Commonly, nurses would note here which injection site they would use next time.

The term 'care plan' proved problematic to interpret in that some of the nurses who stated they used care plans did not have them available, or appeared to be referring to their personal written notes or a Kardex type of format. Shortly after completion of the data collection a new standardized care plan was to be introduced; unfortunately, these were not available during data collection.

The most important type of record, in view of later findings, operating solely in the managerial sector 4 settings, was a computer-based record system, containing information specifically in relation to depot drug clients. This involved nurses completing a pro-forma, recording primarily drug-related information, and involved the assessment of drug side-effects using examination techniques. These pro-formas were then returned and the information added to the patient's record; for forthcoming injections, nurses would receive a report on the client's depot history and any significant drug-related issues.

Although primarily related to the assessment of side-effects, which CPNs are obviously well placed to do given their frequency of contact with clients, and containing no singularly nursing components, the actions taken by the observed nurses in relation to this information system did prove an important factor in the variation of observed care scores. However, this system is used only in relation to clients referred by hospital consultants, and is not used for clients referred to the same CPNs by general practitioners (GPs). Consequently, the assessment of side-effects by the same nurses for GP

referrals was less thorough in the absence of the requirement to complete the pro-forma.

Clients

Since the focus of study was the observation of nurse and client contacts, only a limited amount of information regarding clients was collected.

Gender. Of the 202 contacts, 123 (60.89%) involved male clients and 79 (39.11%) were female. The predominance of contacts involving male clients was repeated across the various types of settings and nurses, and managerial sectors, with no statistically significant differences being revealed.

Age range. The mean age range of all clients was 43.18 years, and ranged from 18 to 70 years. For male clients the mean age was 41.22 years, while for female clients the mean age was 46.23 years. In both cases the range of ages was similar – 20 to 70 years for males and 18 to 69 for females.

Frequency of injections

In Table 4.1 the frequency of contacts in relation to the injection intervals is shown. This indicates that of the 202 contacts, 16 (7.92%) were weekly administrations, 103 (50.99%) were two-weekly, 33 (16.34%) were three-weekly, and 50 (24.75%) were four-weekly or more infrequent. Over half of all contacts involved fortnightly drug administrations, with a mean injection frequency across the whole sample of 2.56 weeks.

Table 4.1 Injection frequency of interactions by types

Injection frequency	*Sex*		*Sectors*				*Nurses*			*Settings*		
	M	*F*	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Weekly	11	5	7	0	5	4	11	5	0	0	9	7
Two-weekly	64	39	20	17	31	35	32	54	17	17	41	45
Three-weekly	18	15	5	5	9	14	8	20	5	5	13	15
Four weeks +	30	20	5	9	12	24	9	32	9	9	12	29

Table 4.2 shows the mean injection frequencies across the gender of clients, the various types of settings and nurses, and managerial sectors. In terms of these various types, there were no significant differences in the pattern of frequencies of depot drug administration across the gender of clients, settings or managerial sectors. There was, however, a significant difference in the frequencies across the types of nurse ($p=<0.05$).

Table 4.2 Mean injection frequencies by types

Settings	*Mean*	*Managerial sectors*	*Mean*	*Nurses*	*Mean*	*Gender*	*Mean*
1	2.74	1	2.22	CPN1	2.25	Male	2.56
2	2.39	2	2.74	CPN2	2.75	Female	2.66
3	2.72	3	2.52	CPN3	2.74	–	–
–	–	4	2.78	–	–	–	–

As Table 4.2 shows, the mean injection frequency of contacts is lowest, at 2.25 weeks, for CPN1 nurses (CPN-based nurses with no post-basic training), while for the other types of CPN the means are almost identical.

The results in Tables 4.1 and 4.2 show that CPN1 nurses accounted for most of the weekly injections, while having proportionately fewer contacts involving injection intervals greater than fortnightly than either of the other types of nurse. For example, 18.33% of CPN1 contacts were weekly drug administrations, which contrasts with only 4.5% for CPN2 nurses, and none for the CPN3 nurses. Therefore, it does appear that those clients requiring the most frequent contacts, and who therefore may be the most chronically unwell, tend to be seen by the non-post-basic trained CPN1 nurses, while their post-basic trained CPN2 colleagues tend to see clients with less frequent injection intervals.

Living alone

Since an aim of this study was to explore the extent to which nurses utilized the contact with clients afforded by the administration of depot drugs, it was considered of value to identify the extent to which this contact might be important to clients themselves; in particular those clients who lived alone and for whom the contact with nurses might be especially relevant.

Of the 202 contacts, 74 (36.63%) involved clients living alone, with there being no significant difference among males and females. Analysis also revealed that the standards of nursing care were not significantly different, as measured using the index, between clients living alone and those living with others. However, the difference in the duration of contact times between clients who live alone and those who live with others was statistically significant ($p=<0.05$), with those living alone tending to experience briefer contacts, with mean contact times of 4.01 minutes for those living alone and 5.30 minutes for those living with others.

This suggests that the standard of nursing care observed was not influenced by whether or not the patient lived alone, although it might be argued that clients living alone might have a greater need for nursing intervention. While significant, the shorter mean contact time for those living alone does not necessarily imply that the contacts were being less fully utilized, since the standard of nursing care was not found to be significantly different than for those clients living with others. A possible explanation for the difference in contact time durations, although supporting data is not available, is that nurses may more often make additional home visits for clients living alone.

Community support

In order to further explore the potential importance of depot attendance to clients, each was asked to identify their most important source of community support. The responses from the 202 contacts show that family supports are the most common; parent or sibling 112 (55.45%), spouse, children or other relatives 37 (18.32%), friends or care staff 52 (25.74%), no response 1 (0.50%).

In relation to gender, the most important community supports identified by clients were significantly different ($p=<0.01$). Seventy-nine of the 123 males (64.23%) identified parents or siblings as being the most important community support, compared with 33 of the 79 females (41.77%). Females, however, more often identified a spouse, child or other relative than did males; 25 of 79 females (31.65%) and 12 of 123 males (9.76%). Similar proportions of each sex identified friends or care staff as community supports.

The difference in important community supports was also significant between clients who lived alone and those who lived with others ($p=<0.01$). Eighty-seven of the 128 (67.97%) clients living with others identified parents or siblings, compared with 25 of the 74 (33.78%) clients who lived alone. Similar proportions identified spouses, children or other relatives, while 37 of the 74 (50.00%) clients living alone identified friends or care staff, compared with 15 of the 128 (11.72%) clients living with others.

The data suggest that those clients who lived alone had less reliance on family supports, possibly because such supports were less available to them. Clients who lived with others indicated that they were predominantly supported by their families, with whom many of the clients presumably lived.

There are, then, significant differences in terms of the sources of community support experienced by clients, of which nurses should obviously be aware in relation to individual clients. The finding that the standard of nursing care was

not significantly different between these two groups, and is at least no worse for clients living alone, is encouraging.

STANDARDS OF NURSING CARE

Within the scope of this chapter, it is not possible to present in detail all of the data regarding standards of care, particularly by describing the findings regarding each of the index criteria. Since analysis has revealed that the observed standard of care and the duration of contacts (time) are significantly correlated, the data presented will include the mean values of care and time across the various types within the sample (settings, nurses and managerial sectors), with only occasional reference to specific index criteria of particular interest. These mean scores are used to illustrate differences and similarities, and readers are reminded that the statistical tests used are not those based on comparisons of these means.

Table 4.3 shows the frequency and percentage of observations for each care and time score. It can be seen that 45 (22.28%) of the 202 observations achieved a care score of only four, the minimum score as described earlier. For these contacts it can be assumed the nursing activities observed related only to drug administration, and that no other type of nursing intervention was evident.

Table 4.3 Frequency of care and time scores

Care score	*Contacts*	*%*	*Time score*	*Contacts*	*%*
4	45	22.28	1	23	11.39
5	31	15.35	2	43	21.29
6	35	17.33	3	31	15.35
7	26	12.87	4	21	10.40
8	14	6.93	5	21	10.40
9	8	3.96	6	12	5.94
10	3	1.49	7	5	2.48
11	12	5.94	8	14	6.93
12	3	1.49	9	9	4.46
13	9	4.46	10	8	3.96
14	8	3.96	11	6	2.97
15	4	1.98	12	1	0.50
16	2	0.99	13	4	1.98
17	2	0.99	14	1	0.50
			15	1	0.50
			19	1	0.50
			23	1	0.50
Mean care = 7.25			Mean time = 4.81		

n = 202

Of these 45 minimum standard observations, 30 occurred in managerial sector 3, with 26 of the 45 being attributed to nurses with post-basic training (CPN2). During these minimal contacts, not only was no attempt made to assess side-effects or oral drug compliance, but no assessment of issues such as the client's sleep pattern, diet, personal hygiene or daily activities was attempted. The finding that over 20% of the nursing contacts observed had no obvious nursing attributes other than the giving of an injection is of obvious concern. Similarly, that almost half of the contacts observed lasted for four minutes or less, with 23 lasting for only one minute, is of equal concern since with such short durations the capacity for any meaningful nursing assessment or intervention to occur must be constrained.

This confirms the findings of both Sladden (1979) and Thomson (1982), in that some of the contacts in this sample were similarly brief. In relation to the standard of nursing care observed, the data does indicate more specific issues of concern, of which the following are illustrations.

Compliance with oral medications

In 105 (54.88%) of the 202 observations nurses failed to address the issue of oral drug compliance, where this was relevant in that clients were receiving some form of oral drug. It was apparent, however, that some nurses, because of prescribing practices, might not even have been aware that their clients were receiving oral drugs. This appeared to be because, for some clients, oral drugs and depot drugs might be prescribed separately by the GP and consultant involved. As a result, nurses may have had a record of only the depot drug regime which they themselves administered since this would involve prescription and drug-recording documentation. However, the nurses may have had no formal information regarding any concurrent oral drug prescribing, usually carried out by GPs. The dosage of oral drugs for some clients would normally be amended when the client saw the GP so that, unless advised by the GP, nurses might have no knowledge of such changes when the client next attended. The field notes do show occasions where the client was able to inform the nurse about oral drug changes, sometimes in response to the nurse asking about the outcome of their GP appointment. Indeed, the field notes also show that nurses often asked when clients had last seen, or were next due to see, either their GP or consultant.

Since many of the drugs taken by clients were of the type prescribed to deal with drug side-effects, then the failure of some nurses to routinely monitor oral drug compliance during depot contacts is of concern. The issues of prescribing arrangements, communication between some nurses and medical staff, and perhaps the level of awareness among nurses of the value of monitoring oral drug compliance during these frequent depot contacts, all appear relevant to this finding.

Other nursing interventions

The research instrument developed (index) was used to record any nursing interventions occurring during each observation. During the main study, over 1200 separate nursing interventions were recorded, of which 606 consisted of the three interventions assumed to occur in each contact, resulting from the administration of an injection. The remaining interventions describe the nursing care observed other than the actual administration of an injection.

For example, in respect of the daily living activities, nurses enquired about sleep patterns during 31 (14.42%) contacts, the client's daily activities in 54 (25.12%) contacts and diet in 22 (10.23%) contacts. In view of the probable needs of such clients, and in terms of the standard of nursing care, the frequency of enquiries on these matters is a cause for concern.

Since all of the clients involved received depot neuroleptic drugs, the monitoring of drug side-effects is an important issue. Given the frequency of contacts, nurses are well placed to meet this need. That oral movement was assessed in only 36 (16.74%) contacts, and tremor in 43 (20.00%) contacts is also of concern, particularly in view of the issues such as tardive dyskinesia. All 36 assessments of oral movement occurred in managerial sector 4, as did almost all attempts to monitor drug side-effects. This probably relates to the demands of the unique computer-based record system used there.

Mean care and time scores

Some indication of the differences within the sample in terms of the standard of nursing care and the duration of contacts (time) is illustrated by showing the respective mean scores.

Table 4.4 shows the care and time means, calculated from all 202 observations, for each setting type. The health centres (setting type 3) are seen to produce the highest means of both care and time, with the hospital clinics (setting type 1) producing the lowest. The differences in contact times shown in Table 4.4 are not statistically significant. The differences in the standard of care across types of setting is significant, however ($p = <0.01$), confirming

Table 4.4 Mean care and time by type of setting

Settings	*Mean care*	*Mean time*
1	5.74	3.39
2	6.24	4.69
3	8.52	5.36

n=202

that observed standards of care were better in health centres (setting type 3), compared with either hospital clinics or CPN offices.

Table 4.5 Mean care and time by type of nurse

Nurses	*Mean care*	*Mean time*
1	7.58	4.93
2	7.49	5.14
3	5.74	3.39

n=202

Table 4.5 shows the care and time means by type of nurse, again calculated from all 202 observations. The hospital clinic nurses produce the lowest means of care and time. The means of the two CPN-based groups indicate similarity, and differences between the two CPN-based types were not statistically significant for either care or time scores. In effect the CPN-based nurses with no post-basic training performed as well as CPN-based nurses who had undergone post-basic training, in terms of nursing interventions observed.

Table 4.6 Mean care and time by managerial sector

Managerial sector	*Mean care*	*Mean time*
1	6.35	5.14
2	5.74	3.39
3	4.86	2.35
4	10.05	7.05

n=202

Table 4.6, like Tables 4.3 and 4.4, shows the means of care and time across all 202 observations, but by managerial sector. Analysis shows that the differences in both care and time scores across the managerial sectors are statistically significant ($p = <0.01$). Managerial sector 4 attains the highest means of both care and time, which is not surprising given that this sector contains six of the eight health centres in which greater care and time scores were obtained.

Interestingly, the lowest mean values of care and time are found in managerial sector 3, which would be expected since 30 of the 45 minimum care standard contacts occurred in this sector. Three of the four nurses observed in managerial sector 3 were CPNs with post-basic training (CPN2).

Caseloads

A possible explanation for the relative performance of sectors, aside from the information system in managerial sector 4 which contributes to care scores there, are the caseload sizes involved, as shown in Table 4.7.

Table 4.7 Nurse/setting case loads by managerial sector

Managerial sector	*Mean nurse caseload*	*Mean setting caseload*
1	52.67	33.81
2	207.00	204.65
3	75.75	46.50
4	53.17	20.49

n=202

The large caseload means shown in managerial sector 2 are due to both settings there being hospital clinics, so that the caseload includes clients who do not receive depot drugs. For the remaining three sectors, the setting caseload means shown are comprised solely of depot clients. Managerial sector 3, which had the lowest mean values of both care and time, shows the largest means in terms of both nurse and setting caseload sizes.

Analysis shows that the size of the nurses' personal caseload is not correlated with the care and time scores observed during depot-related contacts. Many nurses conducting depot 'sessions' also administered depot injections to clients on the caseloads of other nurses, and no correlation with care and time results even when including these other 'informal' clients. However, analysis does reveal a significant inverse correlation between setting caseload sizes and both care and time scores ($p = <0.01$), suggesting that it is more the demands made on individual settings, in terms of the volume of clients attending during 'sessions', rather than the overall workload of individual nurses, which influenced the standard of nursing care observed in depot settings.

The combination of having more depot settings for an approximately similar population, lower setting and personal caseloads, and the unique information system in managerial sector 4, appears to give nurses based there a considerable advantage in terms of standards of nursing care practised as compared with their collegues in the other sectors.

NURSE/CLIENT CONTACTS

Detailed field notes were compiled for each contact. These field notes described

the nature and content of the contact, with particular emphasis on the social and conversational aspects of the contacts: for example, the modes of address used between nurse and client, and conversation topics describing both the manner in which the index issues were dealt with, and the more socially orientated conversation topics.

The field notes were later coded, again by experts, in order to describe the nature of each contact by the allocation of a series of categories. These categories, being descriptive, carry no numerical value. Raters were instructed to consider the description of each contact from the field notes, and to identify which of the following categories adequately described an aspect of the contact. Such a contact could be described in terms of one or all the categories noted below, since they are not mutually exclusive.

The categories used to classify contacts are as follows:

1. Basic. The contact description contains elements primarily related to the administration of the depot injection. Every contact is therefore basic in that an injection is given as a pre-requisite for inclusion in the study.
2. Social. The contact description contains elements of personal social intercourse; such as the use of forenames, or non-clinical conversation topics.
3. Structured. The contact description contains elements which indicate that the nurse used the contact to explore certain issues and/or gather any relevant information.
4. Directive. The contact description indicates that the nurse initiated or reviewed some form of nursing intervention, gave specific direction to the client or took some other form of action in response to particular circumstances.

Social contacts

Only seven of the 202 contacts were considered to have no social components and, as such, it can reasonably be assumed that virtually all the nurse/client contacts at least dealt with the practicalities of depot administration in a socially appropriate manner.

Structured contacts

Of the 202 observed contacts, 136 (67.33%) were considered to be structured, where nurses explored relevant issues in a systematic manner.

As Table 4.8 shows, the majority of structured contacts (52.21%) occurred in managerial sector 4, where 71 of the 77 contacts were structured (92.21%). This is not surprising given that this sector has demonstrated greater

greater care and time scores. Since the remaining sectors reveal similar proportions of structured contacts, the statistically significant ($p=<0.01$) difference in the frequency of structured contacts across managerial sectors further reinforces that better standards of care were observed in managerial sector 4.

Table 4.8 Frequency of structured contacts

	Sector				*Nurse*			*Setting*		
	1	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Unstructured	17	15	28	6	21	30	15	15	25	26
Structured	20	16	29	71	39	81	16	16	50	70

n=202

Across the types of nurse, those attached to a CPN department showed the largest proportions of structured contacts, 72.97% among post-basic trained CPNs (CPN2) and 65.00% among non-post-basic trained CPNs (CPN1), compared with 51.61% for the hospital clinic nurses (CPN3). These differences, however, are not statistically significant. The proportion of structured contacts in health centres and CPN offices are similar, 72.92% and 66.67% respectively, compared with the 51.61% in hospital clinics.

Directive contacts

Of the 202 contacts, only 41 (20.30%) were considered to be directive, where there was evidence of the nurse initiating or reviewing nursing interventions.

Table 4.9 Frequency of directive contacts

	Sector				*Nurse*			*Setting*		
	1	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Not directive	32	24	54	51	53	84	24	24	66	71
Directive	5	7	3	26	7	27	7	7	9	25

n=202

Table 4.9 shows that 26 of the 41 directive contacts occurred in managerial sector 4, where one-third of all contacts were directive. Again this could be expected in this sector given the care and time score findings. Among the remaining sectors the proportions of directive contacts are more variable.

Particularly notable was managerial sector 3, which had significantly lower care and time scores, and where only three of 57 contacts were directive. In managerial sector 1, five of 37 contacts were directive, while in managerial sector 2 the proportion was seven in 31 contacts. It is worth noting that neither of the nurses in managerial sector 2, which had proportionately more directive contacts than either managerial sectors 1 or 3, had post-basic CPN training. The differences in frequencies of directive contacts is significant only across managerial sectors ($p=<0.01$), which again relates to the performance of managerial sector 4.

In terms of care and time, Table 4.10 shows the mean scores in relation to the frequencies of the three contact types. Those contacts designated as not meeting the criteria concerned produced lower means of care and time than those that did. These differences in care and time scores are not significant in relation to social contacts, but are significant in both structured and directive contacts ($p=<0.01$). Therefore, contacts designated as being structured or directive did involve longer durations, and tended to involve a greater range of nursing interventions, and were most often a feature in managerial sector 4.

Table 4.10 Mean care and time scores by contact type

	Not social	*Social*	*Unstructured*	*Structured*	*Not directive*	*Directive*
Mean care	6.29	7.28	5.42	8.13	6.66	9.56
Mean time	3.71	4.85	2.76	5.81	4.11	7.59

n=202

The Appendix to this chapter includes the actual field notes of seven contacts, including the relevant contact classification, time duration and care score. These field notes show the contrasting content of contacts, ranging from one of the seven contacts classified only as basic, lasting only one minute and barely recognizable as being nursing, to the more comprehensive structured and directive contacts.

CONCLUSIONS

Within the confines of this chapter it has been possible only to present a small proportion of all the data collected, and even then to summarize using only means. The background information suggested that nurses might not fully utilize the contact inherent in depot drug administration, and the findings from this study confirm that this is indeed the case for some nurses. However, the data

presented here, along with the information contained in the field notes, also shows that some nurses do make more effective use of these contacts.

The absence of a significant difference between the performance of the CPN-based nurses with post-basic training and those without was surprising. It is suggested that it is the situational factors within some managerial sectors (such as the numbers of settings, setting caseload sizes and the consequent demands on nurses conducting depot clinics) which accounts partly for the absence of evidence that post-basic trained CPNs displayed a higher standard of nursing care; otherwise, the value of post-basic training would become questionable.

The most striking feature in the findings is the variation in scores, and therefore related nursing practices, across this sample. Although all the sample data is contained within a single mental health service, the key variation appears to occur across the four managerial sectors which make up this service.

The performance of managerial sector 4, by comparison with the other sectors, is outstanding. This sector contains more settings, and six of the eight health centre settings in which both care and time scores were greatest, had smaller setting caseloads, while structured and directive contacts were more common here. An important issue which also appears to have contributed to the performance of managerial sector 4 was the presence of the unique computerized information system, the nursing requirements of which contributed to the measurement of nursing care, although the same nurses when dealing with clients not involved with the system did not perform the same interventions as frequently.

The performance of managerial sector 3, which involved three post-basic trained CPNs, was the most disappointing. However, in managerial sector 3 the setting caseload sizes, in view of the significant correlation with care, and personal caseload sizes appear to place higher workload demands on these nurses.

The numbers of settings and the size of setting caseloads do, therefore, appear important, since there are obvious consequences for the workload demands made of nurses during depot injection 'sessions'. The impressions of the researcher are that in the larger caseload settings there was more of a 'production line' approach, however unpalatable this may be, where queueing was common, and where nurses had a limited time to administer the number of injections required. This contrasts with other settings, particularly in managerial sector 4, where the caseload size and scheduling arrangements were conducive to longer and more comprehensive contacts, as the care and time scores and the incidence of structured and directive contacts confirm.

That some nurses administered injections to clients outwith their caseload, as was the case in 45 of the 202 contacts, may appear undesirable, although the data collected shows that these 'informal' contacts did not involve a reduced standard of nursing care. This is probably explained by the predominance of these contacts in managerial sector 4, where prevailing characteristics

allow routine standards of care to be significantly better in any event. There were, however, a number of contacts where the nurse administering the injection either suggested that the client contact their 'own' CPN regarding an issue, or stated that they intended to refer the issue to another CPN.

While it might be argued that dealing separately with the physical injection process allows additional contacts with the client to be used for other issues, this practice has implications for continuity since clients might not feel able to wait to see their 'own' CPN, or might have little control over their difficulties or their understanding of them. To use the depot contact solely to give an injection appears wasteful since, if used more constructively, some additional contacts might be avoided or, if required, their content might be planned more carefully. That nurses might deliberately not assess or explore important issues during an injection contact because a further contact (possibly involving another nurse) would occur in any event, does not appear to represent good nursing practice.

The demands on nurses conducting depot clinics is also related to the prescribing and working arrangements of medical staff, both hospital consultants and general practitioners, where their differing demands and practices will have important effects on the work of the nursing staff involved. This is most marked regarding the prescribing of depot and concurrent oral drugs, where the depot drugs are often prescribed by consultants but concurrent oral drugs are managed typically by general practitioners. It was apparent during observations, and was indeed reported by some nurses, that they were often informed of drug changes by the clients themselves, before being formally advised by medical staff. This is reinforced by the finding that monitoring oral drug compliance with oral drugs was often overlooked by nurses.

There are clearly nursing implications arising from medical prescribing practices, along with any administrative issues regarding the supplying of these drugs to nurses. For some clients the separation of depot and oral prescribing may have consequences in terms of the effective communication of drug changes, the monitoring of oral drug compliance during depot contacts and the standard of nursing care practised.

In relation to the different types of setting, hospital clinics were the less effective than either health centres or CPN offices. However, the working arrangements of these settings, particularly because of the presence of consultant staff, are probably important local factors in the volume of clients attending. The situation here is convenient in some respects; clients could be seen quickly by medical staff, and nurses could obtain prompt advice in situations of concern. This, however, does involve some dependence on a major hospital site, and also involves substantial travelling for some clients in view of the location of these settings in relation to some population centres. The health centres demonstrated the best standard of nursing care. However, it is the location of most of these settings within managerial sector 4, with its unique information system and where better standards of care were routinely achieved, which is the probable cause of this finding.

Given that all of the settings studied relate to a single managerial structure, and the observations were of a relatively homogeneous group of clients and nurses, the variations in standards of care and nursing practice are of obvious interest and concern. The findings from this study indicate that a review would be justified of issues such as the number, location and caseload size of depot settings, communication with medical staff, the nursing implications of prescribing practices and the quality of information available to nurses – if only to raise the standard to that observed in managerial sector 4.

However, if this standard were to be attained across the main study area, the data collected shows that some important and relevant clinical issues are not assessed regularly, even in managerial sector 4. A considerable degree of both professional and managerial commitment would be required to review and, where appropriate, change aspects of depot drug administration arrangements.

Of equal concern is the need to establish an awareness of the potential benefits of more fully, and consistently, utilizing the opportunity afforded by these frequent depot contacts. Within this sample the differences in organizational arrangements and nursing practices observed suggests that a common view of this important event, even with a single management structure, had not been established. Such an awareness should not just be confined to, or expected of, the individual nurses concerned, but should also be an essential responsibility of organizations providing comprehensive and effective mental health care to the population at large.

As noted in the background information, the clients of this type of service do have major mental health care problems and related social and personal needs, which they might not fully appreciate or in some cases be able to articulate. The data shows that a number of clients do value contact with care staff, particularly those who live alone, which for depot drug receivers will most often involve nurses.

The evidence from this study confirms that some nursing contacts related to depot drug administration did involve an acceptable, and at times excellent, standard of nursing care, particularly in managerial sector 4. However, it is the overall variation in the observed standards of care across this single mental health care service organization, albeit with local managerial levels, and the inconsistencies of nursing practice in terms of the range of interventions observed, which are the particularly important findings.

Some clients clearly did not receive an acceptable standard of nursing care, in view of the brevity of their contacts with nurses which, in some cases, involved few recognizable nursing components other than the administration of an injection. For these clients, if the minimum care standard contacts observed represented their only regular nursing contact, then the nursing contribution to their care in the community must be considered unacceptable, and might not accord with the term 'nursing' at all.

Post script

Since this paper was written it has been confirmed that the information system in managerial sector 4 is no longer operational. The nurses, however, report that they continue to monitor drug side-effects using the same techniques, although the information is no longer recorded and disseminated as before.

ACKNOWLEDGEMENTS

The writer would like to acknowledge the support of Professor P. Prophit and Dr F.I. Atkinson, his supervisors at the University of Edinburgh, whose patience and encouragement has been particularly appreciated. The writer also wishes to thank all those nurses and clients who participated in the study, the Scottish Home and Health Department and the Greater Glasgow Health Board.

APPENDIX

Contact 1

Type – basic; setting – health centre; time duration – one minute; care score – 4.

Contact description. Neither nurse nor client use any form of address during the contact. As the client enters the nurse says, 'Where do you want it today?'; the client smiles but does not respond. The nurse, looking at her diary says, 'Left this time', and administers the injection, stating, 'That's it'.

Both exchange goodbyes and the client leaves; the nurse follows to the door and shouts, 'Next'.

Nurse's comment. No comment made.

Contact 2

Type – basic, social; setting – CPN office; time duration – five minutes; care score – 6.

Contact description. Nurse uses client's forename. Client uses no form of address in conversation with the nurse.

Client informs the nurse that she had seen her consultant and that the frequency of her injections was amended to fortnightly. The nurse comments that he had not been told of this yet but would, 'Take your word for it'.

Client comments that this had been the first time she saw her consultant, rather than her GP, for 18 months. The nurse comments it was 'about time' her drug was reviewed.

After the injection both briefly discuss the weather and exchange goodbyes.

Nurse's comments. Is glad client has seen the consultant, since he had been pressing for a drug review and general practitioners were reluctant to alter depot prescriptions. Notes that this particular consultant prefers clients to contact him directly, rather than be referred by a CPN.

Contact 3

Type – basic, social; setting – hospital clinic; time duration – three minutes; care score – 5.

Contact description. Nurse uses client's forename. Client uses no form of address in conversation with the nurse.

Nurse asks about holiday plans and client responds that he has made no holiday arrangements, but volunteers that his mother is 'just back'. Both then discuss holiday matters, such as hotels, in more detail.

Both then discuss local car parking problems and, after the injection, exchange goodbyes.

Nurse's comment. No comment made.

Contact 4

Type – basic, social, structured; setting – health centre; time duration – nine minutes; care score – 11.

Contact description. Both nurse and client use forenames when addressing each other. The client has hearing problems and the nurse speaks more loudly than usual, and appears to deliberately maintain eye contact with the client whenever speaking.

The client comments that she has not seen her consultant for some time and that a recent appointment was cancelled at short notice. The nurse explains that he knows that Dr X is 'very busy', and had to rearrange a number of appointments. He reassures the client that a new appointment will be made soon; the client appears satisfied and this topic ends.

The nurse commences a series of procedures to test for drug side-effects. For each procedure the client asks, 'What is that one for?', and the nurse gives an explanation for each procedure. The client comments that she has been feeling drowsy; the nurse asks for details about how often and what times of day this is most apparent. The client is unable to be specific and the nurse suggests that she mentions this to the consultant when she sees him.

The client asks if the injection can be given in the right buttock; the nurse checks the prescription sheet and says 'Happy to oblige'.

Both exchange goodbyes and the client leaves.

Nurse's comments. Will check that a new consultant appointment has been made and, if not, will arrange it himself since the client is obviously concerned.

Contact 5

Type – basic, social, structured; setting – health centre; time duration – four minutes; care score – 9.

Contact description. The nurse uses client's forename, and also calls him 'love'. Client uses no form of address in conversation with the nurse.

The nurse asks, 'How are you?', to which the client replies that he is 'fine'.

The client volunteers that he is to see his consultant again soon and is hoping that a reduction in drug will be considered. The nurse responds that she is sure the consultant will consider this option since the client is 'doing so well'.

The nurse asked about the client's social life: the client tells the nurse that he went to see a film called *Ghost*, which he enjoyed.

The nurse then asks if the client had seen the disablement resettlement officer at the local Jobcentre. The client informs that he had not, but he intended to. The nurse responds, 'You should; you might have hidden talents': both laugh.

The nurse asks if the clients had experienced any 'troublesome thoughts' recently; the client responds that he had not.

After the injection is given both exchange goodbyes and the client leaves.

Nurse's comments. No particular concerns today. Is on depot drug after a

'first episode' illness, is now well but a little overprotected by his family. Encouraged to see him getting out to the cinema.

Contact 6

Type – basic, social, structured, directive; setting – health centre; time duration – eight minutes; care score – 11.

Contact description. Both nurse and client use forenames when addressing each other. Client has arrived in a wet state, having walked for two miles in heavy rain.

The subject of Invalidity Benefit is raised, and the client informs the nurse that her telephone and electricity supply have been disconnected due to non-payment. The nurse advises the client to contact her social worker and Citizen's Advice Bureau as soon as possible to discuss finances.

The client reports occasional daytime drowsiness but that it is not a problem. The nurse notes this and advises that client to inform her if the drowsiness worsens.

After the injection the nurse asks the client to participate in 'tests for side-effects'. This involves standing and walking: holding the arms outstretched while the nurse observes for tremor, dropping the arm from horizontal, shoulder manipulations by the nurse and tongue protrusion while the nurse observes for movement.

Afterwards both exchange goodbyes and the client leaves.

Nurse's comments. Financial problems are not unusual. Will contact the social worker after the clinic has ended, and will make a home visit as soon as possible.

Contact 7

Type – basic, social, structured, directive; setting – CPN office; time duration – 11 minutes; care score – 8.

Contact description. Nurse uses client's forename. Client uses no form of address. First contact between client and this nurse.

Client states that she 'hasn't been good' for the past week. She saw her consultant yesterday and reports not informing him of having suicidal thoughts, in case she was readmitted to hospital. The nurse asks what is meant by 'not feeling good', and the client describes hearing voices telling her to 'run into the traffic'.

The nurse suggests that it would be advisable to inform the consultant of her feelings and asks her approval to telephone him; the nurse advises that he would be unhappy if she were to leave before he has spoken to the consultant. The client agrees to the nurse telephoning. Before leaving the room the nurse asks about the client's appetite and sleep pattern.

The nurse returns after three minutes and tells the client that she can go home and that an appointment had been made for her to see the consultant again tomorrow.

The injection is given, both exchanging goodbyes, with the nurse telling the client to 'take care till then'.

Nurse's comments. The suicidal thoughts are of concern but since this was the first contact he has with this client he is happy to follow the consultant's advice. He will make a particular effort to 'get to know her as quickly as possible'.

REFERENCES

Boettcher, E.G. and Alderson, S.F. (1983) Psychotropic medications and the nursing process. *Journal of Psychosocial Nursing and Mental Health Services*, 20(11), 12–16.

Cheadle, A.J., Freeman, H.L. and Korer, J. (1978) Chronic schizophrenic patients in the community. *British Journal of Psychiatry*, 132, 221–7.

Clark, A.F. and Holden N.L. (1987) The persistence of prescribing habits: a survey and follow-up of prescribing in chronic hospital in-patients. *British Journal of Psychiatry*, 150, 88–91.

Eberhard, G. and Hellbom, E. (1986) Haloperidol decanoate and flupenthixol decanoate in schizophrenia. *Acta Psychiatrica Scandinavica*, 74, 255–62.

Freeman, G. and Alpert, M. (1966) Prevalence of schizophrenia in an urban population. *British Journal of Psychiatry*, 149, 603–11.

Holloway, F. (1988) Prescribing for the long-term mentally ill: a study of treatment practices. *British Journal of Psychiatry*, 152, 511–15.

Hunter, P. (1978) *Schizophrenia and Community Psychiatric Nursing*, National Schizophrenia Fellowship, Surbiton, Surrey.

Irons, P.D. (1978) *Psychotropic Drugs and Nursing Intervention*, McGraw Hill, New York.

Kendell, R.E. (1983) Schizophrenia, in *Companion to Psychiatric Studies*, 3rd edn, eds. R.E. Kendell and A.K. Zealley), Edinburgh, pp 275–96.

Leff, J.P. and Wing, J.K. (1971) Trial of maintenance therapy in schizophrenia. *British Medical Journal*, 3, 559–604.

McCreadie, R.G, Robinson, A.D. and Wilson, A.O.A. (1984) The Scottish survey of chronic day patients. *British Journal of Psychiatry*, 145, 626–30.

Pasamanick, B., Scarpitti, F.R., Lefton, M. *et al.* (1969) Home vs hospital care for schizophrenics. *Journal of the American Medical Association*, 178, 177–81.

Robinson, A.D.T. and McCreadie, R.G. (1986) The Nithsdale schizophrenia survey

V. Follow-up of tardive dyskinesia at 3.5 years. *British Journal of Psychiatry*, 149, 621–3.
Sladden, S. (1979) *Psychiatric Nursing in the Community: A Study of the Working Situation*, Churchill Livingstone, Edinburgh.
Thomson, R.V. (1982) *Community Psychiatric Nursing in Clwyd: A Comparative Study of Community Psychiatric Nursing in North and South Clwyd*, thesis for MSc degree, University of Manchester.
Turner, G.N. (1984) A census of out-patients attending for depot medication at a Glasgow psychiatric hospital. *Health Bulletin*, 42(3), 141–5.
Waltz, C.F., Strickland, O.L. and Lenz, E.R. (1986) *Measurement in Nursing Research*, F.A. Davis, Philadelphia.
Wooff, K., Goldberg, D.P. and Fryers, T. (1988) The practice of community psychiatric nursing and mental health social work in Salford. *British Journal of Psychiatry*, 152, 783–92.

CHAPTER FIVE

Human immunodeficiency virus (HIV) disease and drug misuse – research issues for CPNs

Jean Faugier

INTRODUCTION

Human immunodeficiency virus (HIV) disease poses a range of practice issues for CPNs and there is a growing body of research which, while not addressing the direct involvement of CPNs with those individuals with HIV disease, nevertheless begins to inform our approach to the prevention and care issues in the community.

There are, of course, the obvious effects of HIV disease, presenting as they do a great complexity and diversity of emotional and psychological problems which affect every aspect of a person's life. Such stresses can, in turn, further diminish the immune response, often leaving the individual caught in a vicious circle of stress and illness. The CPN has a role to play in providing essential emotional and psychological support and assessment for all those people and their loved ones who are affected by HIV disease. Diagnosis with a life-threatening disease of the nature of HIV will produce a myriad of responses, ranging from a positive approach to despair and hopelessness.

HIV also has the ability to strip away people's anonymity, thereby identifying them as a member of a socially stigmatized minority. This may frequently happen before the individuals concerned or their loved ones have had time to come to terms with their feelings about the situation.

Many CPNs will no doubt feel quite comfortable with a support and treatment role directed at psychological stresses, or in fact discrete examples of anxiety and depression. However, one of the major challenges of HIV disease